SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Occupational Accident Insurance Policy - Forms*		
Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Occupational Accident Insurance Policy - Forms	SERFF Tr Num: ZURC-126350669	State: Arkansas
TOI: H03G Group Health - Accidental Death & Dismemberment	SERFF Status: Closed-Approved-Closed	State Tr Num: 43840
Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment	Co Tr Num: CW AH 29187	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Patricia Chudik	Disposition Date: 11/04/2009
	Date Submitted: 10/21/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: CW AH 29187 - Occupational Accident Insurance Policy - Forms	Status of Filing in Domicile: Authorized
Project Number: CW AH 29187	Date Approved in Domicile: 10/01/2009
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Other
Filing Status Changed: 11/04/2009	Explanation for Other Group Market Type: Motor Carriers or other entities that hire transportation -related independent contractors
	State Status Changed: 11/04/2009
Deemer Date:	Created By: Patricia Chudik
Submitted By: Patricia Chudik	Corresponding Filing Tracking Number:

Filing Description:

This is a new Group Occupational Accident Insurance product designed to provide accidental death and dismemberment benefits to transportation-related independent contractors for losses resulting primarily from occupational injuries. Please note, however, this Group Occupational Accident Insurance product is not a substitute for

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
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Workers' Compensation coverage.

This Group Occupational Accident Insurance product will be marketed to groups in your state consisting of two (2) or more individuals and may be marketed through brokers, consultants, third party administrators and sales employees.

All forms are new and are not intended to replace any other forms currently in use.

Company and Contact

Filing Contact Information

Patricia Chudik, Product Analyst	pat.chudik@zurichna.com
1400 American Lane	847-605-7714 [Phone]
Schaumburg, IL 60196-1056	847-605-7768 [FAX]

Filing Company Information

Zurich American Insurance Company	CoCode: 16535	State of Domicile: New York
1400 American Lane	Group Code: 212	Company Type:
Schaumburg, IL 60102	Group Name:	State ID Number:
(847) 605-6000 ext. [Phone]	FEIN Number: 36-4233459	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Arkansas's fee for a policy and associated forms is $50.00.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	$50.00	10/21/2009	31457376

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/04/2009	11/04/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	10/29/2009	10/29/2009	Patricia Chudik	11/04/2009	11/04/2009

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
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Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

Disposition

Disposition Date: 11/04/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Occupational Accident Insurance Policy - Forms*		
Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanatory memorandum and statement of variables	Approved-Closed	Yes
Supporting Document	Redlined copies tracking changes to forms	Approved-Closed	Yes
Form *(revised)*	[Truckers] [Occupational] Accident Insurance Policy	Approved-Closed	Yes
Form	[Truckers] [Occupational] Accident Insurance Policy	Replaced	Yes
Form	Group Application Occupational Accident Insurance	Approved-Closed	Yes
Form *(revised)*	[Truckers] [Occupational] Accident Insurance Certificate	Approved-Closed	Yes
Form	[Truckers] [Occupational] Accident Insurance Certificate	Replaced	Yes
Form	Enrollment and Beneficiary Designation Form	Approved-Closed	Yes
Form	Blank Endorsement	Approved-Closed	Yes

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Occupational Accident Insurance Policy - Forms*		
Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/29/2009
Submitted Date	10/29/2009
Respond By Date	

Dear Patricia Chudik,

This will acknowledge receipt of the captioned filing.

Objection 1

- [Truckers] [Occupational] Accident Insurance Policy, U-OA-400-A AR (08/09) (Form)
- [Truckers] [Occupational] Accident Insurance Certificate, U-OA-402-A AR (08/09) (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/04/2009
Submitted Date	11/04/2009

Dear Rosalind Minor,

Comments:
Thank you for your correspondence regarding this filing.

Response 1

Comments: We have amended our policy and certificate in accordance with your comments.

I have also provided redlined copies tracking the changes to our forms in the supporting documentation.

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Occupational Accident Insurance Policy - Forms*		
Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

Related Objection 1

Applies To:

- [Truckers] [Occupational] Accident Insurance Policy, U-OA-400-A AR (08/09) (Form)
- [Truckers] [Occupational] Accident Insurance Certificate, U-OA-402-A AR (08/09) (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redlined copies tracking changes to forms

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
[Truckers] [Occupational] Accident Insurance Policy	U-OA-400-A AR (08/09)		Policy/Contract/Fraternal Certificate	Initial		45.000	11-03-09U-OA-400-A AR - [Truckers][Occupatio nal] Accident Policy.pdf
Previous Version							
[Truckers] [Occupational] Accident Insurance Policy	*U-OA-400-A AR (08/09)*		*Policy/Contract/Fraternal Certificate*	*Initial*		*45.000*	U-OA-400-A AR - [Truckers][Occupatio

					nal] Accident Policy.pdf
[Truckers] [Occupational] Accident Insurance Certificate	U-OA-402-A AR (08/09)	Certificate	Initial	48.000	11-03-09U-OA-402-A AR - [Truckers][Occupational] Accident Certificate.pdf
Previous Version					
[Truckers] [Occupational] Accident Insurance Certificate	*U-OA-402-A AR (08/09)*	*Certificate*	*Initial*	*48.000*	U-OA-402-A AR - [Truckers][Occupational] Accident Certificate.pdf

No Rate/Rule Schedule items changed.

Please contact me if you have additional questions or concerns.

Sincerely,
Patricia Chudik

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Occupational Accident Insurance Policy - Forms*		
Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

Form Schedule

Lead Form Number: U-OA-400-A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/04/2009	U-OA-400-A AR (08/09)	Policy/Contract/Fraternal Certificate	[Truckers] [Occupational] Accident Insurance Policy	Initial		45.000	11-03-09U-OA-400-A AR - [Truckers][Occupational] Accident Policy.pdf
Approved-Closed 11/04/2009	U-OA-401-A AR (08/09)	Application/Enrollment Form	Group Application Occupational Accident Insurance	Initial		50.000	U-OA-401-A AR - Group Application.pdf
Approved-Closed 11/04/2009	U-OA-402-A AR (08/09)	Certificate	[Truckers] [Occupational] Accident Insurance Certificate	Initial		48.000	11-03-09U-OA-402-A AR - [Truckers][Occupational] Accident Certificate.pdf
Approved-Closed 11/04/2009	U-OA-403-A AR (08/09)	Application/Enrollment Form	Enrollment and Beneficiary Designation Form	Initial		50.000	U-OA-403-A AR - Enrollment and Beneficiary Designation Form.pdf
Approved-Closed 11/04/2009	U-OA-404-A CW (08/09)	Policy/Contract/Fraternal Certificate: Amendmen	Blank Endorsement	Initial		48.000	10-20-09 U-OA-404-A CW - Administrative Change

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Occupational Accident Insurance Policy - Forms*		
Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

t, Insert Page, Endorsement or Rider

Endorsement.pdf

[Truckers] [Occupational] Accident Insurance Policy

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

This **Policy** is a legal contract between the **Policyholder** and the **Company**. The **Company** agrees to insure eligible persons of the **Policyholder** (herein called **Insured Person(s)**) against loss covered by this **Policy**, subject to its provisions, limitations and exclusions. The persons eligible to be **Insured Persons** are all persons described in the eligibility section of the **Schedule**.

This **Policy** is issued in consideration of the payment of the required premium when due and the statements set forth in the signed Group Application, which is attached to and made part of this **Policy** and in the individual enrollment forms, if any.

This **Policy** begins on the Policy Effective Date shown in the **Schedule**. This **Policy** will continue in effect, provided premiums are paid when due, until the Policy Termination Date set forth in the **Policy**, unless otherwise terminated as further provided in this **Policy**, or renewed.

Please refer to the **Policy** for the special meaning of words and phrases that appear in bold.

Various provisions in this **Policy** restrict coverage. Read the entire **Policy** carefully to determine an **Insured Person's** rights and duties and what is and is not covered.

THIS POLICY PROVIDES ACCIDENT COVERAGE ONLY
THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

IMPORTANT NOTICE
THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.

This **Policy** is governed by the laws of the state in which it is delivered.

In return for the payment of premium, and subject to the terms of this **Policy**, coverage is provided as stated in this **Policy**.

IN WITNESS WHEREOF, this **Company** has executed and attested these presents and, where required by law, has caused this **Policy** to be countersigned by its duly Authorized Representative(s).

Nancy D. Mueller

President

Corporate Secretary

PLEASE READ THIS POLICY CAREFULLY

TABLE OF CONTENTS

THIS POLICY IS NOT WORKERS' COMPENSATION AND DOES NOT REQUIRE PRE-AUTHORIZATION OF A PHYSICIAN FOR COVERED SERVICES OR TREATMENT. THE INSURED PERSON MAY CONSULT THE COMPANY AT [1-888-889-5330] TO DETERMINE IF A SERVICE OR TREATMENT IS COVERED. THE COMPANY CAN PROVIDE THE INSURED PERSON WITH THE NAME AND ADDRESS OF A PHYSICIAN WHO IS A PREFERRED PROVIDER.

THE **INSURED PERSON** CANNOT BE COVERED BY ANY OTHER OCCUPATIONAL ACCIDENT POLICY ISSUED BY THE **COMPANY**. IF THE **INSURED PERSON** PAYS PREMIUM BUT IS NOT ELIGIBLE FOR COVERAGE OR DOES NOT QUALIFY FOR BENEFITS UNDER THIS **POLICY**, THE **COMPANY** WILL REFUND ANY UNEARNED PREMIUM PAID IN ERROR.

SECTION I - SCHEDULE

Policy Effective Date: [01/01/09]
[**Policy Period**: [01/01/09] to [01/01/10]]
Policy Premium Due Date: [01/01/09]
Policy Number: [XXXXXX-XX]

Insured Person's Premium: [$0.00]

Policyholder: [Name of Trucking Company]
[Address]
[City, State, Zip]

Eligible Persons

The following persons are eligible to become **Insured Persons** under this **Policy**:

CLASS I: **Actively at Work Owner/Operators** who have enrolled for coverage under this **Policy**.
CLASS II: **Actively at Work Contract Drivers** who have enrolled for coverage under this **Policy**.

Benefits Summary

	Occupational Injuries	**Non-Occupational Injuries**
☐ Accidental Death Benefit:		
Principal Sum*	[$50,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Survivor's Benefit:		
Principal Sum*	[$175,000.00]	[$7,500.00]
Monthly Benefit Percentage of **Principal Sum**	[1.0%]	[1.0%]
Monthly Benefit Amount	[$1,750.00]	[$1,750.00]
☐ Accidental Dismemberment Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accidental Paralysis Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accident Medical Expense Benefit:		
Commencement Period	[90 days]	[90 days]
Deductible Amount	[$0.00]	[$0.00]
Maximum Benefit Amount	[$1,000,000.00]	[$5,000.00]
Maximum Benefit Period	[104 weeks]	[52 weeks]
Dental Benefit Maximum	[$2,500.00]	[$1,000.00]
Lifetime **Maximum Benefit Amount**	[$1,000,000.00]	[$10,000.00]
Physical, Occupational, or Work Hardening Therapies	To a maximum-combined [36] visits	[N/A]
Ambulance for Medically Necessary Services	[1] round trip to and from a **Hospital** to a Maximum	[1] round trip to and from a **Hospital** to a Maximum

	Occupational Injuries of [$10,000.00] per **Accident**	**Non-Occupational Injuries** of [$10,000.00] per **Accident**
Acupuncture Care and Chiropractic Care	[$1,000.00] per **Injury**	N/A
[Hernia Coverage]	[$10,000.00]	N/A
[Hemorrhoid Coverage]	[$10,000.00]	N/A
Mental and Nervous or Depressive Condition	1 visit per day to a maximum of [$25.00] per visit and [20] visits per **Accident**	N/A
[**Occupational Cumulative Trauma**]	[$20,000.00]	N/A
[**Occupational Disease**]	[$20,000.00]	N/A
☐ Temporary Total Disability Benefit:		
Commencement Period	[90 days]	[90 days]
Waiting Period	[7 days]	[7 days]
Benefit Percentage	[70.0%]	[70.0%]
Minimum Weekly Benefit Amount	[$125.00]	[$125.00]
Maximum Weekly Benefit Amount	[$500.00]	[$500.00]
Maximum Benefit Period**	[104 weeks]	[12 weeks]
[**Maximum Benefit Period** for Hernia]	[90 days]	N/A
[**Maximum Benefit Period** for Hemorrhoid]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Disease**]	[90 days]	N/A
☐ Continuous Total Disability Benefit: ***		
Waiting Period	[equals **Maximum Benefit Period** for **Temporary Total Disability**]	N/A
Benefit Percentage	[70.0%]	N/A
Minimum Weekly Benefit Amount	[$50.00]	N/A
Maximum Weekly Benefit Amount	[$500.00]	N/A
Maximum Benefit Amount	[$300,000.00]	N/A
Maximum Benefit Period	Up to age 70, but not beyond full Social Security retirement age	N/A
☐ Additional Benefits:		N/A
[Return of Remains Benefit]	[Refer to SECTION VI]	N/A
[Non-Medical Repatriation Benefit]	[Refer to SECTION VI]	N/A
[After School Care Benefit]	[Refer to SECTION VI]	N/A
[Coma Benefit]	[Refer to SECTION VI]	N/A
[Critical Burn Benefit]	[Refer to SECTION VI]	N/A
[Day Care Benefit]	[Refer to SECTION VI]	N/A
[Felonious Assault Benefit]	[Refer to SECTION VI]	N/A
[Higher Education Benefit]	[Refer to SECTION VI]	N/A
[Hijacking Benefit]	[Refer to SECTION VI]	N/A
[Vehicle Modification Benefit]	[Refer to SECTION VI]	N/A
[Seat Belt Benefit]	[Refer to SECTION VI]	N/A
[Spouse Retraining Benefit]	[Refer to SECTION VI]	N/A
Limits of Liability:		
Combined Single Limit of Liability	[$1,000,000.00]	[$10,000.00]
Aggregate Limit of Liability	[$2,000,000.00]	[$15,000.00]
Sub Limits of Liability:		

	Occupational Injuries	Non-Occupational Injuries
[**Combined Single Limit of Liability** for:		
[Hernia]	[$20,000.00]	N/A
[Hemorrhoid]	[$20,000.00]	N/A
[**Occupational Disease**]	[$50,000.00]	N/A
[**Occupational Cumulative Trauma**]	[$50,000.00]	N/A

* Starting at age [65], the **Principal Sum** shall be based on the following schedule:

Age at Date of Loss	Percent of **Principal Sum**
[65]	[80%]
[66]	[60%]
[67]	[40%]
[68]	[20%]
[69]	[15%]
[70 and over]	[10%]

** If an **Insured Person** suffers an **Injury** at or after age [70], the **Maximum Benefit Period** shall be [one (1) year].

*** If an **Insured Person** sustains an **Injury** within six months or less of attaining his or her full Social Security retirement age, as defined by the United States Social Security Administration, the **Insured Person** does not qualify for the Continuous Total Disability Benefit.

SECTION II - GENERAL DEFINITIONS

Accident means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while coverage is in effect under the **Policy**.

Actively at Work means under **Dispatch** for at least [30] hours each week.

Aggregate Limit of Liability shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

Assignment means the **Policyholder** has offered and the **Insured Person** has accepted a shipment of freight as recorded in the books and records of the **Policyholder** in the ordinary course of business.

Company means Zurich American Insurance Company.

Co-Owner means a person who has partial ownership of a vehicle operating as an **Owner/Operator**.

Combined Single Limit of Liability means, with respect to any one **Insured Person**, the maximum amount that the **Company** will pay for all **Covered Loss** under this **Policy** for or in connection with **Injury** to an **Insured Person** resulting from any one **Accident**. When the **Combined Single Limit of Liability** has been reached, no further benefits shall be payable under this **Policy**, with respect to that **Insured Person**, for or in connection with **Injury** sustained as the result of that one **Accident**.

Commencement Period means the period between the date of the **Accident** that caused the **Injury** and the date on which the **Covered Loss** must occur for benefits to be payable under the Accidental Death Benefit, the Accidental Dismemberment Benefit, Accidental Paralysis Benefit, Accident Medical Expense Benefit and/or the Temporary Total Disability Benefit.

Contract Driver means an individual who:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [is authorized by an **Owner/Operator** to operate a power unit owned or leased by an **Owner/Operator** and must neither own nor lease the power unit;]
3. [is compensated on a basis other than time expended in the performance of work;]

4. [is responsible for determining the route and time for **Assignment**;]
5. [has the principal duty to operate the power unit;]
6. [is classified as an independent contractor by the **Policyholder** and the **Owner/Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance, or for any other purpose, [unless workers' compensation coverage is not mandatory for such person as an employee of either the **Policyholder** or **Owner/Operator**];] and
7. [receives for federal income tax reporting purposes a 1099 and not a W-2].

Covered Loss, in the singular or plural, means one or more of the losses or expenses identified in Sections V and VI of this **Policy** that are not specifically excluded herein.

Cumulative Trauma or Repetitive Conditions means **Non-Occupational** conditions that impair the normal physiological function of the body over an extended period, but do not arise as the result of a single **Accident**.

Dependent Child(ren) means the **Insured Person's** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption, who are:
1. under age 19 or under age 23 if he or she [:] [(a)] is enrolled in accredited institution of higher learning on a full-time basis, [and (b) relies on the **Insured Person** for more than 50% of his or her support and is taken as a dependent on the Federal Income Tax Return of the **Insured Person**]; or
2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the **Insured Person** for support and maintenance as defined herein.

The **Company** may require proof of the **Dependent Child(ren)'s** incapacity and dependency before the **Dependent Child(ren)** reached the age limit specified above. The **Company** may request that satisfactory proof of the **Dependent Child(ren)'s** continued incapacity and dependency be submitted to the **Company** on an annual basis.

Dispatch means the time during which an **Insured Person** is on **Assignment** or is performing tasks prior to or after an **Assignment** to prepare the contracted vehicle for a current or future **Assignment**. **Dispatch** must be authorized by the **Policyholder** and includes the following:
1. in route to pick up a load;
2. picking up a load;
3. in route to delivering a load;
4. unloading a load;
5. the waiting time for a load;
6. returning from delivering a load;
7. in route to, returning from or performing a pre-trip inspection as required by a recognized governmental agency and/or the contracted motor carrier;
8. [while performing vehicle maintenance or repairs on the contracted vehicle during any of the foregoing times; and]
9. [while performing verifiable vehicle maintenance or repairs on the contracted vehicle; and]
10. performing activities to comply with federal or state laws or to satisfy contracted motor carrier requirements.

Eligible Person(s) means a Class I or Class II individual described in the **Schedule**.

Household Member means a person who maintains residence at the same address as the **Insured Person** and is not an **Immediate Family Member**.

Immediate Family Member means an **Insured Person's Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, stepparent, brother, sister, stepbrother, stepsister, child, child who has been legally adopted, or stepchild.

Injury, in the singular or plural, means bodily injury caused by an **Accident**, which occurs while the **Insured Person** is covered under this **Policy** and the **Injury** must result directly and independently of all other causes, in a **Covered Loss**. All **Injuries** sustained by an **Insured Person** in any one **Accident** shall be considered a single **Injury**.

Insured Person(s) means an **Owner/Operator** or **Contract Driver**:
1. who is enrolled for coverage under this **Policy**;
2. who has paid the required premium when due; and
3. whose coverage is in effect under this **Policy**.

Maximum Benefit Amount means the maximum amount that the **Company** will pay under the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Amount** is shown in the **Schedule**.

Maximum Benefit Period means the maximum period that the **Company** will pay benefits, after the **Waiting Period**, under the Temporary Total Disability Benefit, the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Period** is shown in the **Schedule**.

Maximum Weekly Benefit Amount means the maximum amount that the **Company** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Maximum Weekly Benefit Amount** is shown in the **Schedule**.

Mental and Nervous or Depressive Condition means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.

Minimum Weekly Benefit Amount means the minimum amount that the **Company** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Minimum Weekly Benefit Amount** is shown in the **Schedule**.

Non-Occupational means benefits payable for an **Injury** due to an **Accident** sustained by an **Insured Person** while not under **Dispatch**.

Occupational means, with respect to an activity, **Accident**, incident, circumstance or condition involving an **Insured Person**, that the activity, **Accident**, incident, circumstance or condition occurs or arises out of or in the course of the **Insured Person** performing services within the course and scope of contractual obligations for the **Policyholder**, and while under **Dispatch**. **Occupational** does not encompass any period during the course of everyday travel to and from work, other than as allowed under **Dispatch**, or while on vacation.

Occupational Assessment means a test of vocational capabilities, including review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), and evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

Occupational Cumulative Trauma means bodily injury that impairs the normal physiological function of the body caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time and does not arise as the result of a single **Accident**, when:
1. such condition is diagnosed by a **Physician**;
2. the **Insured Person's** last day of last performance of the activities causing the bodily injury occurred while the **Insured Person's** coverage is in effect; and
3. such bodily injury resulted directly, and independently of all other causes, in a **Covered Loss**.

Occupational Disease means a sickness that results in disability or death, and is caused by exposure to environmental or physical hazards during the course of the **Insured Person's Occupational** activities, when:
1. such sickness is diagnosed by a **Physician** and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards;
2. exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which the **Insured Person** performs **Occupational** activities;
3. the **Insured Person's** last day of last exposure to the environmental or physical hazards causing such sickness occurs while the **Insured Person's** coverage is in effect; and
4. such exposure results directly and independently of all other causes in a **Covered Loss**.

Owner/Operator means an individual who leases to or from the **Policyholder** and:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [owns or leases a power unit;]
3. [is responsible for the maintenance and operating costs of the power unit, including, but not limited to fuel, repairs and supplies;]
4. [is compensated on a basis other than time expended in the performance of work;]
5. [is responsible for determining the route and time for **Assignment**;]
6. [has the right to select or reject the load;]

7. [has a written contract or **Assignment** from the **Policyholder** and is classified as an independent contractor by the **Policyholder** and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;] and
8. [receives for federal income tax reporting purposes a 1099 not a W-2].

Physician means a qualified medical doctor acting within the scope of his or her license who is not:
1. the **Insured Person**;
2. an **Immediate Family Member**;
3. a **Household Member**; or
4. a practitioner retained by the **Policyholder**.

Policy means this [Truckers] [Occupational] Accident Insurance Policy.

Policyholder means the entity named as **Policyholder** in the **Schedule**.

Policy Period means the period shown in the **Schedule**, subject to prior termination pursuant to Section III of this **Policy**.

Pre-Existing Condition means a condition for which an **Insured Person** has sought or received medical advice or treatment at any time during the twelve months immediately preceding his or her effective date of coverage under this **Policy**.

Principal Sum means the maximum amount that the **Company** will pay under the Accidental Death Benefit, the Survivor's Benefit, the Accidental Dismemberment Benefit or the Accidental Paralysis Benefit. The applicable **Principal Sum** is shown in the **Schedule** and is subject to the **Combined Single Limit of Liability** and the **Aggregate Limit of Liability**.

Schedule means SECTION I of this **Policy**.

Spouse means the **Insured Person's** legal spouse.

Third Party in the singular or plural means, but is not limited to, the following:
1. the party that caused the **Accident**, **Injury** or other medical condition and any insurer or indemnifier thereof;
2. the **Insured Person's** insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers; or
3. any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the **Accident**, **Injury** or other medical condition.

Waiting Period means the consecutive number of days an **Insured Person** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Policy**. Temporary Total Disability Benefits and Continuous Total Disability Benefits are [not] retroactive to the first day of disability. The **Waiting Period** is shown in the **Schedule**.

SECTION III - EFFECTIVE DATES AND TERMINATION DATES

Policy Effective and Termination Dates

1. Policy Effective Date. This **Policy** begins on the Policy Effective Date shown in the **Schedule** at 12:01 A.M. Standard Time at the address of the **Policyholder** where this **Policy** is delivered.

2. Policy Termination Date. This **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of:
   a. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   b. the date specified in the written notice of the **Company's** intent to terminate this **Policy**, which will be at least [thirty (30)] days after the date the **Company** sends such notice to the **Policyholder's** last known recorded address;
   c. the date specified in the written notice of the **Policyholder's** intent to terminate this **Policy**, which will be at least [thirty (30)]days after the date the **Policyholder** sends such notice to the **Company**; or
   d. at the expiration of the **Policy Period**.

If the **Company** terminates this **Policy**, any unearned premium will be returned on a pro-rata basis. If the **Policyholder** requests termination, the **Company** will return any unearned premium paid on a pro-rata basis. Termination will not affect any claim for a **Covered Loss** occurring prior to the effective date of termination.

Owner/Operator's Effective and Termination Dates

1. **Owner/Operator's** Effective Date. An **Owner/Operator's** coverage under this **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Owner/Operator** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Owner/Operator's** Termination Date: An **Owner/Operator's** coverage under this **Policy** ends on the earliest of:
   a. the date this **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   c. the date the **Owner/Operator** requests, in writing, that his or her coverage be terminated; or
   d. the date the **Owner/Operator** ceases to be an **Insured Person**.

Contract Driver's Effective and Termination Dates

1. **Contract Driver's** Effective Date. A **Contract Driver's** coverage under this **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Contract Driver** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Contract Driver's** Termination Date. A **Contract Driver's** coverage under this **Policy** ends on the earliest of:
   a. the date this **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   c. the date the **Contract Driver** requests, in writing, that his or her coverage be terminated;
   d. the date the **Contract Driver** ceases to be an **Insured Person**; or
   e. the date the **Owner/Operator**, with whom the **Contract Driver** is under contract, ceases to be an **Insured Person** and/or whose contract with the **Policyholder** terminated.

A change in an **Insured Person's** coverage under this **Policy** due to a change in the **Insured Person's** eligible class or benefit selection becomes effective on the later of: (1) the date the change in his or her eligible class or benefit selection occurs; or (2) if premium change is required, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

SECTION IV - PREMIUMS

PREMIUMS

Premiums are payable to the **Company** in the amount shown in the **Schedule**. The **Company** may change the required premiums due by giving the **Policyholder** at least [sixty (60) days] advance written notice. The **Company** may change the required premiums as a condition of any renewal of this **Policy**. The **Company** may also change the required premiums at any time when any change affecting premiums is made in this **Policy**.

The **Company** may re-underwrite and may change the terms and conditions of this **Policy** including the premium rate on the date when the number of **Insured Persons** under this **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [fifteen percent (15%)] or more. The **Policyholder** shall provide the **Company** with written notice of

such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.

PLAN AND EXPOSURE CHANGES
The **Policyholder** must notify the **Company** of any subsidiary or affiliated company that is to be covered under this **Policy**. Such notice must be sent within [thirty (30) days] of the acquisition of such subsidiary or affiliated company. If such notice is not provided, the newly acquired entity will not be considered a part of the **Policyholder** and the owner/operators or contract drivers will not be **Insured Persons** until the date that notice is provided. The **Company** has the right to decline coverage or adjust premium based on the changing exposure.

INSURED PERSON'S PREMIUM
The **Insured Person's** Premium is shown in the **Schedule** and shall be payable as follows:
1. the **Insured Person** who enrolled on or prior to the fifteenth (15th) day of the month shall pay an amount equal to the full monthly premium. No premium shall be payable for the last full or partial month of coverage; and
2. the **Insured Person** who enrolled after the fifteenth (15th) day of the month shall pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, the **Insured Person** shall pay an amount equal to the monthly premium.

INSURED PERSON'S GRACE PERIOD
A grace period of [thirty-one (31) days] will be provided for the payment of any **Insured Person's** Premium due after the first premium. The **Insured Person's** coverage will not be terminated for non-payment of premium during this grace period if the **Insured Person** pays the premium due by the last day of this grace period. The **Insured Person's** coverage will terminate if the full amount of the premium due is not paid by the last day of this grace period.

POLICY GRACE PERIOD
A grace period of [thirty-one (31)] days will be provided for the payment of any premium due after the first premium. This **Policy** will not be terminated for nonpayment of premium during this grace period if the **Policyholder** pays all premiums due by the last day of this grace period. This **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of this grace period. No Policy Grace Period will be provided if the **Company** receives notice to terminate this **Policy** prior to a premium due date.

If the **Company** expressly agrees to accept late payment of a premium without terminating this **Policy**, the **Company** does so in accordance with the Noncompliance With Policy Requirements provision in Section X of this **Policy**. In such case, the **Policyholder** will be liable to the **Company** for any unpaid premiums for the time this **Policy** is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by the **Company** in the collection of all overdue amounts.

WAIVER OF PREMIUM
During the period in which an **Insured Person** is receiving a Temporary Total Disability Benefit or Continuous Total Disability Benefit, premiums will be waived from the first premium due date on or after the benefit begins to the premium due date following the date the benefit ceases, at which time premium payments must resume. If premium payments are not resumed on that date, the **Insured Person's** coverage under this **Policy** shall terminate on that date. The **Insured Person** is responsible for reporting Waiver of Premium to the **Policyholder** or an authorized person designated by the **Policyholder** or the **Company**.

SECTION V - BENEFITS

ACCIDENTAL DEATH BENEFIT
If **Injury** to the **Insured Person** results in death within the **Commencement Period**, the **Company** will pay the **Principal Sum** to the beneficiary in accordance with the Payment of Claims provision in Section IX of this **Policy**.

SURVIVOR'S BENEFIT
If an Accidental Death Benefit is payable under this **Policy**, the **Company** will pay the **Monthly Benefit Amount**, up to the **Principal Sum**, to the **Insured Person's** surviving **Spouse**.

If the **Insured Person** is not survived by a **Spouse**, or if the **Insured Person's Spouse** dies or remarries, the **Company** will pay or continue to pay the Survivor's Benefit to the **Insured Person's** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. Payment of the **Monthly Benefit Amount** will end on the earliest of the following:

1. the date the **Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date the last **Dependent Child** dies or is no longer a **Dependent Child**; or
3. the date the **Principal Sum** has been paid.

If the **Insured Person** is not survived by a **Spouse** or any **Dependent Child(ren)**, the **Company** will not pay a Survivor's Benefit.

For this benefit, the following definition applies:

Monthly Benefit Amount means the product of the Monthly Benefit Percentage shown in the **Schedule** multiplied by the **Principal Sum**.

EXPOSURE AND DISAPPEARANCE BENEFIT

If an **Insured Person** is exposed to weather because of an **Accident**, which results in a **Covered Loss**, the **Company** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the body of the **Insured Person** has not been found within one year after the disappearance, stranding, sinking or wrecking of a power unit in which he or she was an occupant, then it will be presumed, subject to all other terms and provisions of this **Policy**, that the **Insured Person** has suffered Accidental Death within the meaning of this **Policy**. If the **Insured Person** is found and identified, the **Company** has the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to the **Insured Person** results in any one of the **Losses** specified below within the **Commencement Period**, the **Company** will pay the Percentage of the **Principal Sum** shown below:

For **Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	[100%]
Sight of Both Eyes	[100%]
One Hand and One Foot	[100%]
One Hand and the Sight of One Eye	[100%]
One Foot and the Sight of One Eye	[100%]
One Hand or One Foot	[50%]
Sight of One Eye	[50%]
Thumb and Index Finger of Same Hand	[25%]
Speech and Hearing	[50%]
Speech or Hearing	[25%]

If more than one **Loss** is sustained by an **Insured Person** as a result of the same **Accident**, only one amount, the largest, will be paid.

For this benefit, the following definition applies:

Loss, in the singular or plural, of a hand or foot means complete severance through or above the wrist or ankle joint; **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye; and **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

PARALYSIS BENEFIT

If **Injury** to the **Insured Person** results in any Type of Paralysis specified below within the **Commencement Period**, the **Company** will pay the Percentage of the **Principal Sum** shown below:

Type of Paralysis:	Percentage of the **Principal Sum**

Quadriplegia	[100%]
Paraplegia	[75%]
Hemiplegia	[50%]
Uniplegia	[25%]

If the **Insured Person** sustains more than one Type of Paralysis as a result of the same **Accident**, only the largest single amount will be considered a **Covered Loss**.

For this benefit, the following definitions apply:

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**.

Paraplegia means the complete and irreversible paralysis of both lower **Limbs**.

Hemiplegia means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body.

Uniplegia means the complete and irreversible paralysis of one **Limb**.

Limb, in the singular or plural, means entire arm or entire leg.

TEMPORARY TOTAL DISABILITY BENEFIT

If **Injury** to the **Insured Person** results in **Temporary Total Disability** within the **Commencement Period** and the **Insured Person** is under age [70] on the day the **Temporary Total Disability** begins, the **Company** will pay the following amount, after the **Waiting Period**:

1. for each week of a **Temporary Total Disability** during a **Single Period of Total Disability** the Temporary Total Disability Benefit is equal to the lesser of:
   a. the Benefit Percentage shown in the **Schedule** of the **Average Weekly Earnings**; or
   b. the **Maximum Weekly Benefit Amount**;
2. for less than a full **Benefit Week** of **Temporary Total Disability**, the Temporary Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. the date the **Insured Person** is no longer **Temporarily Totally Disabled**;
2. the date the **Insured Person** dies;
3. the date the **Maximum Benefit Period** has been reached; or
4. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to the **Company**.

For this benefit, the following definitions apply:

Average Weekly Earnings means:

1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income the **Insured Person** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income the **Insured Person** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will

use [seventy-five percent (75%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation provided he/she was not an **Owner/Operator**. If he/she was an **Owner/Operator**, then we will use 33% of the gross income.]

Insured Person must produce proof of his or her gross income and the number of weeks worked. Otherwise, the **Company** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the **Maximum Weekly Benefit Amount**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the first day of **Temporary Total Disability** after the **Waiting Period** and on the same day of each week thereafter.

Continuous Care means monthly monitoring or evaluation of the disabling condition by a **Physician**. The **Company** must receive proof of continuing **Temporary Total Disability** on a monthly basis.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following, which are considered separate periods of disability:
1. successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which the **Insured Person** is not **Temporarily Totally Disabled**; or
2. successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least six (6) months during which the **Insured Person** is not **Temporarily Totally Disabled**.

Temporary Total Disability or Temporarily Totally Disabled means disability that:
1. prevents an **Insured Person** from performing the **Material and Substantial Duties** of his or her occupation [as a commercial truck driver];
2. requires the care and treatment of a **Physician**; and
3. requires that and results in the **Insured Person** receiving **Continuous Care**.

If the **Insured Person** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured Person** shall not qualify for the Temporary Total Disability Benefit. During this period, the **Insured Person** cannot engage in any activity which results in earned income.

Material and Substantial Duties means a duty or duties which the **Insured Person** is required to perform under the terms of the written contract with the **Policyholder** or **Owner/Operator** and as described in the **Insured Person's** application.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Temporary Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which the **Insured Person's** dependents may qualify because of the **Insured Person's** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; and
4. the amount the **Insured Person** receives as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

The **Insured Person** must provide tax schedules and returns to the **Company** for the purpose of calculating this offset.

CONTINUOUS TOTAL DISABILITY BENEFIT
If **Injury** to the **Insured Person** resulting in **Temporary Total Disability** subsequently results in **Continuous Total Disability**, the **Company** will pay the following, after the **Waiting Period**:

1. for each month of a **Continuous Total Disability**, the Continuous Total Disability Benefit is four and three-tenths (4.3) times the **Weekly Benefit Amount** for **Temporary Total Disability**; or
2. for less than a full **Benefit Week** of **Continuous Total Disability**, the Continuous Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Continuous Total Disability**, but only if:
   a. Temporary Total Disability Benefits ceased solely because the **Maximum Benefit Period** has been reached, but the **Insured Person** remains disabled;
   b. the **Insured Person** is not within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration, on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached;
   c. the **Insured Person** has been granted a Social Security disability award for his or her disability (if the **Insured Person** cannot meet the credit requirement for a Social Security disability award he or she cannot qualify for the Continuous Total Disability Benefit even if he or she would otherwise qualify);
   d. the **Insured Person's** disability is reasonably expected to continue without interruption until he or she dies and is substantiated by objective medical evidence satisfactory to the **Company**;
   e. the **Injury** resulting in a **Continuous Total Disability** occurred before the **Insured Person** is within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration; [and]
   f. the **Injury** began within the **Commencement Period** [.] [; and]
   g. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**.]

The Continuous Total Disability Benefit shall cease on the earliest of the following:
1. the date the **Insured Person** is no longer **Continuously Totally Disabled**;
2. the date the **Insured Person** dies;
3. the date the **Insured Person's** Social Security disability award ceases;
4. the date the **Maximum Benefit Period** has been reached;
5. the date that the **Maximum Benefit Amount** has been paid; or
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to the **Company**.

For this benefit, the following definitions apply:
Average Weekly Earnings will be calculated as follows:
1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income the **Insured Person** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income the **Insured Person** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [seventy-five percent (75%)] of the average gross income received by the other **Insured Persons**, who were contracted within the last three (3) months prior to the covered **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation provided he/she was not an **Owner/Operator**. If he/she was an **Owner/Operator**, then we will use 33% of the gross income.]

The **Insured Person** must produce proof of his or her gross income and the number of weeks worked. Otherwise, the **Company** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the Maximum Weekly Benefit. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Total Disability or Continuously Totally Disabled means disability that:
1. prevents an **Insured Person** from performing the duties of any occupation for which he or she is qualified by reason of education, training or experience;
2. requires the care and treatment of a **Physician**; and
3. requires that, and results in, the **Insured Person** receiving **Continuous Care**.

The **Company** must receive proof of continuing **Continuous Total Disability** on a quarterly basis; provided however, that the **Company** may waive requirements 2 and 3. If the **Insured Person** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured Person** shall not qualify for **Continuous Total Disability**. During this period, the **Insured Person** cannot engage in any activity which results in earned income.

Continuous Care means at least quarterly monitoring or evaluation of the disabling condition by a **Physician**.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Continuous Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which the **Insured Person's** dependents may qualify because of the **Insured Person's** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; or
4. the amount the **Insured Person** receives as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

The **Insured Person** must provide tax schedules and returns to the **Company** for the purpose of calculating this offset.

ACCIDENT MEDICAL EXPENSE BENEFIT
If an **Insured Person** suffers an **Injury** requiring treatment by a **Physician** within the **Commencement Period**, the **Company** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Services or Charges** received or incurred due to such **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** for all **Injuries** caused by a single **Accident**, subject to any applicable **Deductible Amount**.

For this benefit, the following definitions apply:
Ambulatory Medical Center means a facility that:
1. operates under the laws of the state in which it is situated;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility.

Ambulatory Medical Center does not include a **Hospital**, **Physician's** office or clinic.

Custodial Services means any services which are not intended primarily to treat a specific injury. **Custodial Services** include, but shall not be limited to, services:
1. related to watching or protecting the **Insured Person**;
2. related to performing or assisting the **Insured Person** in performing any activities of daily living, such as:
   a. walking;
   b. grooming;
   c. bathing;
   d. dressing;
   e. getting in or out of bed;
   f. toileting;
   g. eating;
   h. preparing foods; or
   i. taking medications that can usually be self-administered; and

3. that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment means equipment of a type that is designed primarily for use by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a spa or a stationary bicycle).

Deductible Amount means the total amount of **Medically Necessary Services or Charges** that must be paid by the **Insured Person** before any Accident Medical Expense Benefit is paid under this **Policy**. The **Company** shall not be responsible for any **Medically Necessary Services or Charges** within the **Deductible Amount** as set forth in the **Schedule**.

Extended Care Facility means an institution that meets all of the following requirements:
1. operates under the laws of the state that it is situated in;
2. is approved by the United States Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a registered nurse;
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment of an **Insured Person** in his or her home as part of a treatment plan prescribed by the attending **Physician**, which is provided by a **Hospital** or agency certified to provide such services, but only if it:
1. begins within [seven (7)] days after discharge from a **Hospital**; and
2. follows a **Hospital** confinement of [five (5)] days or more.

Hospital means a facility that:
1. operates under the law of the state in which it is situated;
2. is approved by the United States Department of Health and Human Services or its successor;
3. has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
4. has 24-hour nursing service by registered nurses on duty or on call; and
5. is supervised by one or more **Physicians**.

A **Hospital** does not include:
1. a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care;
2. a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, or any ward, room, wing or other section of a hospital that is used for such purposes; or
3. any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Medically Necessary Services or Charges means one or more of the following, but only if each: (a) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (b) meets generally accepted standards of medical practice; and (c) is ordered by a **Physician** and performed under his or her care, supervision or order:
1. **Hospital** room and board charges or room and board charges in an intensive care unit; **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room); use of an **Ambulatory Medical Center**; and **Hospital** charges for in-patient treatment of a **Mental and Nervous or Depressive Condition**, as shown in the **Schedule**;
2. treatment by a **Physician** of a covered **Mental and Nervous or Depressive Condition** due to an **Injury**, as shown in the **Schedule**;
3. Ambulance service to or from a **Hospital**, as shown in the **Schedule**;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. Physical, Occupational or Work Hardening Therapies, Chiropractic Care and Acupuncture, as shown in the **Schedule**;
9. **Durable Medical Equipment** rental charges, up to the actual purchase price of such equipment;
10. the initial supply, but not any replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes;
11. medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;

12. repair or replacement of **Sound Natural Teeth** damaged or lost as a result of **Injury**, up to the Dental Benefit Maximum, if any, shown in the **Schedule**;
13. **Extended Care Facility**; or
14. **Home Health Care**.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary Services or Charges** for the care and treatment of the **Injury**, including but not limited to: (1) a non-essential private **Hospital** room; (2) television rental; and (3) **Hospital** telephone charges.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary Charge(s) means an amount(s) that:
1. does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and
2. does not include charges that would not have been made if no insurance existed[; and
3. does not exceed the cost of a generic drug, if available. The **Company** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available].

ACCIDENT MEDICAL EXPENSE BENEFIT EXCLUSIONS
In addition to the General Exclusions and Limitations in Section VIII of this **Policy**, **Medically Necessary Services or Charges** do not include expenses for or resulting from any of the following:
1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
2. dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. eye glasses or contact lenses;
4. hearing aids or hearing examinations;
5. rental of **Durable Medical Equipment** if the total rental expense exceeds the usual purchase price for similar equipment in the locality where the expense is incurred, unless authorized by the **Company**;
6. **Custodial Services**;
7. **Personal Comfort or Convenience Items**;
8. services of any government **Hospital** for which an **Insured Person** is not liable for payment;
9. any expenses covered by [Medicare, Medicaid,] a **Third Party** [or any other insurance];
10. expenses incurred which are more than the **Usual and Customary Charge**;
11. cosmetic, plastic or restorative surgery unless otherwise covered;
12. expenses which the **Insured Person** is not legally obligated to pay;
13. an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;
14. any mileage costs or lodging expenses, unless authorized by the **Company**;
15. any translation costs, unless authorized by the **Company**; or
16. **Home Health Care** services provided by an **Immediate Family Member** or **Household Member**.

SECTION VI - ADDITIONAL BENEFITS

[**RETURN OF REMAINS BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay for the transport of the body or remains (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to the **Insured Person's** county of residence. We must be contacted prior to the transportation of the body or remains and we must pre-authorize the transportation for coverage to apply. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**NON-MEDICAL REPATRIATION BENEFIT**

If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accident Medical Expense Benefit and has sufficiently recovered to travel in a regularly scheduled economy class air flight, commercial bus or train and without special medical equipment or personnel with a minimal risk to his or her health, the **Company** will pay for the return to his or her principal residence. We must be contacted prior to the transport and we must agree to the travel itinerary for coverage to apply. This benefit is subject to the prior recommendation of the attending **Physician**. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**AFTER SCHOOL CARE BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit for after school care to the individual who incurs the expense on behalf of each **Dependent Child** who is [ten (10)] years old or less, up to a maximum of the lesser of:
1. [two percent (2%)] of the applicable **Principal Sum** paid under the Accidental Death Benefit per year; or
2. [two thousand dollars ($2,000)] per year.

The after school care provider may not be an **Immediate Family Member** and written proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, to establish continued eligibility for this benefit.

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child** is under age [ten (10)] at the time of each payment. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**COMA BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** and within three hundred sixty-five (365) days of the **Accident** which caused such **Injury**, such **Injury** causes the **Insured Person** to be in a **Coma** for at least thirty-one (31) consecutive days, the **Company** will pay an additional benefit equal to [one percent (1%)] of the **Principal Sum** for such **Injury**, and such amount will be paid each month the **Insured Person** remains in a **Coma** following the initial thirty-one (31) day period. At the end of eleven (11) months of payment, if the **Insured Person** remains in a **Coma**, the **Company** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the eleven (11) months of benefit already received.

The Coma Benefit will end on the earliest of the following:
1. the date the **Insured Person** is no longer in the **Coma**; or
2. the date the **Insured Person** has received a Coma Benefit for eleven (11) months.

The **Company** may require receipt of written proof, at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Coma means a condition determined as such by the **Company's** duly licensed **Physician**.]

[**CRITICAL BURN BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss**, the **Company** will pay an additional benefit equal to the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)], but only if the **Insured Person**:
1. suffered second degree or higher burns over [twenty-five percent (25%)] of his or her body; and
2. has undergone reconstructive surgery to treat the burned areas of the body within three hundred sixty-five (365) days of the occurrence of the **Accident** that caused the **Injury**.]

[**DAY CARE BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit for day care expenses to the individual who incurs the expense for each **Dependent Child** if:
1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and

2. the **Dependent Child** is under age [thirteen (13)].

The Day Care Benefit will be equal to the lesser of:
1. the actual cost of the day care;
2. [three percent (3)%] of the **Principal Sum**; or
3. [three thousand dollars ($3,000)];

and will be paid annually for [four (4)] consecutive years if:
1. the **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. written proof acceptable to the **Company** is received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Accredited Child Care Facility means a properly licensed childcare facility that operates pursuant to state and local laws and has a Tax Identification Number issued by the Internal Revenue Service. **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**FELONIOUS ASSAULT BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** for an **Occupational Injury** payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Paralysis Benefit as a result of a **Felonious Assault** by someone other than himself or herself, an **Insured Person** or an **Immediate Family Member** or **Household Member**, the **Company** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum**, but only if:
1. the **Felonious Assault** occurs while the **Insured Person** is under **Dispatch**; and
2. the crime directly involves the **Policyholder's** or the **Insured Person's** funds or assets.

For this benefit, the following definition applies:

Felonious Assault means the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]

[**HIGHER EDUCATION BENEFIT**
If the **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay a benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**, but only if on the date of the **Accident**, the **Dependent Child**:
1. is enrolled as a full-time student in an accredited college, university or trade school; or
2. is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The Higher Education Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit for all **Dependent Child(ren)** combined is [twenty thousand dollars ($20,000)].]]

[**HIJACKING BENEFIT**
The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions and Limitations of this **Policy** is modified and an **Injury** directly resulting from a **Hijacking** or any attempt at any **Hijacking** is covered under this **Policy**.

This benefit will continue beyond the actual **Hijacking** while the **Insured Person** is:
1. subject to the control of the person(s) making the **Hijacking**; and

2. traveling directly to the **Insured Person's** home or original destination.

For this benefit, the following definition applies:

Hijacking means the unlawful seizure or wrongful exercise of control of a power unit occupied by the **Insured Person**, while the **Insured Person** is getting into, riding in, or getting out of and while under **Dispatch**.]

[**VEHICLE MODIFICATION BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Dismemberment Benefit or Paralysis Benefit, the **Company** will pay an additional benefit equal to the actual cost for modifications to his or her motor vehicle that are necessary to make it accessible or drivable, but only if such **Injury** requires the **Insured Person** to use a wheelchair. Benefits are not payable unless:
1. the modifications are made by a person(s) experienced in such modifications and are recommended by an organization recognized for providing support and assistance to wheelchair users; and
2. proof sufficient to the **Company** is received by the **Company**, establishing eligibility for this benefit.

The maximum amount payable under this benefit will be the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)].]

[**SEAT BELT BENEFIT**
If an **Insured Person** suffers an **Injury** directly resulting from an automobile **Accident** resulting in a **Covered Loss** payable under the Accidental Death Benefit or Survivor's Benefit, the **Company** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum** up to a maximum of [ten thousand dollars ($10,000)], but only if the **Insured Person** was:
1. operating or riding as a passenger in a motorized vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Accident**.

The **Insured Person's** actual use of the seat belt or lap and shoulder restraints must be verified in the official law enforcement report of the **Accident**, through certification by the investigating officers; or by other reasonable proof, acceptable to the **Company**.]

[**SPOUSE RETRAINING BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit to his or her **Spouse** for the actual cost of any state licensed professional or trade-training program in which the **Spouse** enrolls and completes, but only if the purpose of the program is to obtain an independent source of support and maintenance and the actual cost is incurred within [thirty (30)] months from the death of the **Insured Person**.

The Spouse Retraining Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Spouse** continues his or her training. Before this benefit is paid each year, proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit is [twenty thousand dollars ($20,000)].]

SECTION VII - LIMITS OF LIABILITY

The **Combined Single Limit of Liability** shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Loss** with respect to an **Insured Person** arising out of **Injury** sustained by such individual as the result of any one **Accident** or Occurrence. The term Occurrence means a single event or related events or originating cause occurring within a 24-hour period.

The **Aggregate Limit of Liability** shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

If either the **Combined Single Limit of Liability** or the **Aggregate Limit of Liability** is not enough to pay all **Covered Loss**, the **Company** will pay reduced benefit amounts based upon the proportion that the **Covered Loss** bears to each benefit or expected total benefits that would otherwise be payable. If the total benefits are unknown, the **Company** will determine the total expected benefits for each **Insured Person**.

Limitation on Multiple **Covered Loss**. If an **Insured Person** suffers more than one **Covered Loss** under one benefit as a result of the same **Accident**, the **Company** will pay only up to the largest **Covered Loss** amount.

Limitation on Multiple Benefits. If an **Insured Person** can recover benefits under two or more of the Accidental Death Benefit, Accidental Dismemberment Benefit, [Coma Benefit] or the Accidental Paralysis Benefit as a result of the same **Accident**, the **Company** will pay only up to the highest applicable **Principal Sum**.

SECTION VIII - GENERAL EXCLUSIONS AND LIMITATIONS

This **Policy** does not cover any losses contributed to or caused by, in whole or in part, by any of the following:

1. [suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** or any **Injury** resulting from a provoked attack;]
2. [sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning [or routine and temporary non chronic sickness or illness such as a cold, cough, headache or nausea];]
3. [a **Pre-existing Condition**, until the **Insured Person** has been continuously covered under this **Policy** for [twelve (12)] consecutive months;]
4. [**Occupational Cumulative Trauma** or **Cumulative Trauma and Repetitive Conditions**, unless shown in the **Schedule**;]
5. [**Occupational Disease**, unless shown in the **Schedule**;]
6. [performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;]
7. [declared or undeclared war, or any act of declared or undeclared war;]
8. [full-time active duty in the armed forces of any country or international authority;]
9. [any **Injury** for which the **Insured Person** is entitled to benefits pursuant to any workers' compensation law or other similar legislation;]
10. [any loss insured by employers' liability insurance;]
11. [the **Insured Person** being intoxicated:
    a. the **Insured Person** is conclusively deemed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the **Injury** occurs; and
    b. an autopsy report from a licensed medical examiner, law enforcement officer reports or similar items will be considered proof of the **Insured Person's** intoxication;]
12. [the **Insured Person** being under the influence of any illegal substance, drug, narcotic, or hallucinogen, unless such drug, narcotic, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage;]
13. [the **Insured Person's** commission of or attempt to commit a felony or a Class A misdemeanor;]
14. [travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the **Insured Person** is:
    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or the **Insured Person**;]
15. [skydiving, parasailing, hang-gliding, bungee-jumping [or any similar activity];] [or]
16. [charges incurred for treatment of a covered **Injury**, when the **Insured Person** obtains compensation for the covered **Injury** from a **Third Party**].

[INCARCERATION LIMITATION

Benefits provided to an **Insured Person** will cease while the **Insured Person** is incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when the **Insured Person** is released from such facility.]

SECTION IX - CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be received by the **Company** within twenty (20) days after an **Insured Person's** loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the **Company** at Zurich American Insurance Company Group Accident Claims Division, [P.O. Box 968041 Schaumburg, IL 60196] with information sufficient to identify the **Insured Person**, is deemed notice to the **Company**.

CLAIM FORMS
The **Company** will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within thirty (30) days after the giving of notice, the claimant will be deemed to have met the Proof of Loss requirements upon submitting, within the time fixed in this **Policy** for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the **Insured Person's** name, the **Policyholder's** name and the Policy Number.

PROOF OF LOSS
Written Proof of Loss acceptable to the **Company** must be received by the **Company** within ninety (90) days after the date of the loss. If the loss is one for which this **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proof acceptable to the **Company** must be received by the **Company**, at such intervals as the **Company** may reasonably require, establishing continued eligibility for the benefit. Failure to furnish such proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time such proof is otherwise required. The **Company** has a right to investigate any documents that the **Insured Person** shall make available to the **Company** upon request.

PAYMENT OF CLAIMS
Upon receipt of written proof of death, payment for loss of life of an **Insured Person** will be made to the **Insured Person's** beneficiary or, if there is no beneficiary designated, the **Insured Person's** survivors in the following order:
1. the **Insured Person's Spouse**;
2. the **Insured Person's** child(ren);
3. the **Insured Person's** parents;
4. the **Insured Person's** brothers and sisters;
5. the **Insured Person's** estate.

Upon receipt of written Proof of Loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the **Insured Person**. If the **Insured Person** dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary or, if there is no beneficiary designated, the **Insured Person's** survivors in the order as listed above.

BENEFICIARY DISIGNATION AND CHANGE
The **Insured Person's** designated beneficiary(ies) is (are) the person(s) so named by the **Insured Person** as shown on the **Policyholder's** records kept on this **Policy**.

A legally competent **Insured Person** over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the **Policyholder** with a written request for change. When the request is received by the **Policyholder**, whether the **Insured Person** is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the **Company** on account of any payment which is made prior to receipt of the request.

Except for the Survivor's Benefit, if there is no designated beneficiary or no designated beneficiary is living after the **Insured Person's** death, payment will be made to the **Insured Person's** estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding one thousand dollars ($1,000) may be made, at the **Company's** option, to any relative by blood or connection by marriage of the payee, who, in the **Company's** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

The **Company** shall pay benefits directly to any **Hospital** or person rendering covered services, unless the **Insured Person** requests otherwise in writing and provides proof that payment was made directly to such **Hospital** or person. Such request must be made no later than the time Proof of Loss is filed. Any payment the **Company** makes in good faith fully discharges the **Company's** liability to the extent of the payment made.

TIME OF PAYMENT OF CLAIM
Benefits payable under this **Policy** for any loss other than loss for which this **Policy** provides any periodic payment will be paid within thirty (30) days upon the **Company's** receipt of written Proof of Loss. Benefits payable periodically under this **Policy** will be paid at four (4) week intervals during the continuance of the period for which the **Company** is liable, subject to the **Company's** receipt of written Proof of Loss, and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

REHABILITATION
The **Company** will consider paying for a rehabilitation program for the **Insured Person** based on an **Occupational Assessment** provided he or she is receiving benefits under either the **Temporary Total Disability Benefit** or the **Continuous Total Disability Benefit**. The rehabilitation program must be mutually agreed upon by the **Insured Person** and the **Company**. The extent of the **Company's** participation will be determined solely by the **Company**. Any benefits payable will continue during the **Insured Person's** rehabilitation unless otherwise agreed to by the **Company**.

SUNSET
In no event shall benefits under this **Policy** be payable unless written Proof of Loss is received by the **Company** within [three (3) years] from the date of the **Accident**.

[**ARBITRATION**
Any contest to a claim denial under this **Policy** shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration shall occur at the offices of the American Arbitration Association nearest to the **Insured Person** or the person claiming to be the beneficiary. The arbitrator(s) shall not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Insured Person** or the person claiming to be the beneficiary is a citizen of a state where the law does not allow binding arbitration in an insurance policy but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. [Non-binding arbitration is required and no legal action may be brought by the **Insured Person**, the beneficiary, or the **Company** until thirty (30) days after the arbitrator(s) issues a non-binding award.] This provision bars the institution of any individual or class action lawsuit brought by the **Insured Person** or the beneficiary.]

SECTION X - GENERAL PROVISIONS

ENTIRE CONTRACT
This **Policy**, together with any riders, endorsements, amendments, applications, enrollment forms and attached papers, if any, make up the entire contract between the **Policyholder** and the **Company**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by an **Insured Person** will be used in any contest unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or personal representative.

No changes in this **Policy** will be valid until approved by an officer of the **Company**. The approval must be noted on or attached to this **Policy**. No agent may change this **Policy** or waive any of its provisions.

CERTIFICATE OF INSURANCE
The **Company** will provide the **Policyholder** with a Certificate of Insurance, in either paper or electronic format, for delivery to each **Insured Person**, where required by state law. Such Certificate of Insurance will contain a summary of terms that affect benefits.

INCONTESTABILITY
The validity of this **Policy** will not be contested after it has been in force for two year(s) from the Policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

POLICYHOLDER RECORDS
The **Policyholder** will keep a record of the coverage, premium, beneficiary designation and other pertinent administrative information for each **Insured Person** which, if acceptable to the **Company**, shall be deemed to be a part of this **Policy**. The **Company** may examine these records at any reasonable time while the **Policy** is in force and for six (6) years after the termination of this **Policy**. The **Policyholder** will report to the **Company** within a reasonable time all changes in information regarding an **Insured Person**. [The **Policyholder** shall indemnify the **Company** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the administration described herein.]

PHYSICAL EXAMINATION AND AUTOPSY
The **Company** has the right, at its own expense, to examine the **Insured Person** whose **Injury** is the basis of a claim, when and as often as it may be reasonably required while a claim is pending. The **Company** may also require an autopsy where it is not prohibited by law.

LEGAL ACTIONS
In those states where binding arbitration is not allowed, no legal action for a claim can be brought against the **Company** until sixty (60) days after receipt of written Proof of Loss. In those states where binding arbitration is not allowed, no legal action for a claim can be brought against the **Company** more than three (3) years (six (6) years in South Carolina and Wisconsin, five (5) years in Kansas, Florida and Tennessee) after the time for giving written Proof of Loss. In those states where binding arbitration is allowed, binding arbitration shall supersede this provision.

NONCOMPLIANCE WITH POLICY REQUIREMENTS
Any express waiver by the **Company** of any requirements of this **Policy** will not constitute a continuing waiver of such requirements. Any failure by the **Company** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

CONFORMITY WITH STATE STATUTES
Any provision of this **Policy** that, on its effective date, is in conflict with the statutes of the state in which the **Policy** was delivered, is hereby amended to conform to the minimum requirements of such laws.

CLERICAL ERROR
Clerical error, whether by the **Policyholder**, the Producer or the **Company**, in keeping records pertaining to this **Policy**, will not:
1. invalidate coverage otherwise validly in force; or
2. continue coverage otherwise validly terminated.

DATA REQUIRED
The **Policyholder** must maintain adequate records acceptable to the **Company** and provide any information required by the **Company** relating to this insurance.

AUDIT
The **Company** will have the right to inspect and audit, at any reasonable time, all records and procedures of the **Policyholder** that may have a bearing on this insurance.

ASSIGNMENT
This **Policy** is non-assignable.

SUBROGATION
The **Company** has the right to recover all payments including future payments, which the **Company** has made to the **Insured Person** or on behalf of the **Insured Person's** covered dependents, heirs, guardians or executors or will be obligated to pay in the future to the **Insured Person**, from any **Third Party**. If the **Insured Person** recovers from any **Third Party**, the **Company** will be reimbursed first from such recovery to the extent of the **Company's** payments to the **Insured Person**. The **Insured Person** agrees to assist the **Company** in preserving its rights against any **Third Party**, including but not limited to, signing subrogation forms supplied by the **Company**.

[**MADE WHOLE DOCTRINE**
The **Company** has the right to recover any and all first monies paid (or payable) to or on behalf of the **Insured Person** and to any and all claims of or on behalf of the **Insured Person**, to the extent of benefits paid by this **Policy**, and regardless of whether or not the beneficiary has been made whole. Made whole shall include first dollar recovery with no offset for attorneys' fees.]

RIGHT TO RECOVER OVERPAYMENTS
In addition to any rights of recovery, reimbursement or subrogation provided to the **Company** herein, when payments have been made by the **Company** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this **Policy**, the **Company** shall have the right to recover such excess payment, from any person to whom such payments were made. The **Company** maintains the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under the **Policy** to the extent of the overpayment.

CONDITIONAL CLAIM PAYMENT
If an **Insured Person** suffers a **Covered Loss** as the result of an **Injury** for which a **Third Party** may be liable, the **Company** will pay the amount of benefits otherwise payable under this **Policy**. However, if the **Insured Person** receives payment from the **Third Party**, the **Insured Person** agrees to refund to the **Company** the lesser of:
1. the amount actually paid by the **Company** for such **Covered Loss**; or
2. an amount equal to the sum actually received from the **Third Party** for such **Covered Loss**.

If the **Insured Person** does not receive payment from the **Third Party** for such **Covered Loss**, the **Company** reserves the right to subrogate under the Subrogation clause of this **Policy**.

At the time such **Third Party** liability is determined and satisfied, this amount shall be paid whether determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.

[**OFFSET DEBT**
The **Company** will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from the **Policyholder** to the **Company** against any balance or balances, whether on account of losses or otherwise, due from the **Company** to the **Policyholder**.]

[**CLAIMS FOR WORKERS' COMPENSATION AND OTHER INSURANCE**
No benefits shall be payable under this **Policy** for any loss for which the **Insured Person** claims or files for any workers' compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, the **Company** shall determine its liability under this **Policy**. The **Company** reserves the right to recover, from the **Insured Person**, any benefits paid under this **Policy** that are subsequently paid for under any workers' compensation, employers' liability, occupational disease or similar law or any other insurance.]

[Workers' Compensation Indemnification. If an **Insured Person** is determined by a court of law or the appropriate state regulatory authority to be covered under workers' compensation insurance for a **Covered Loss**, any benefits for which the **Insured Person** is eligible under this **Policy**, are payable to the person who was determined to be the **Insured Person's** employer or such person's designee or assignee.]

SECTION XI – IMPORTANT NOTICE

The Insured Person may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if they need assistance in resolving any complaints. Or, the Insured Person may write to Zurich American Insurance Company at their administrative offices at [XXXXXX].

Should the Insured Person wish to contact the Arkansas Insurance Department for assistance, they may do so by calling [1-800-282-9134]. Or, the Insured Person may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

Group Application

Occupational Accident Insurance

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

APPLICANT INFORMATION

Applicant's Legal Name: _____ USDOT #: _____ Tax ID #: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Facsimile: _____ Website: _____

Contact Person: _____ Email: _____

Are Subsidiaries/Affiliates to be covered? ☐ Yes ☐ No If Yes, please provide a list of complete names and addresses of all to be covered.

BENEFIT OPTIONS

Please select benefit options below:

Occupational Accident:

Accidental Death & Dismemberment Benefit *****: ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ Other $

***** Death benefits are paid in a partial lump sum and the balance payable to surviving dependents, if any.

Accident Medical Expense Maximum Benefit Amount: ☐ $1,000,000 ☐ Other $_____

Accident Medical Expense Maximum Benefit Period: ☐ 104 Weeks ☐ Other _____ weeks

Temporary Total Disability Maximum Weekly Benefit Amount: ☐ $500.00 ☐ $600.00 ☐ Other $_____

Temporary Total Disability Maximum Benefit Period: ☐ 104 Weeks ☐ Other _____ weeks

Continuous Total Disability Benefit Coverage: Included, unless otherwise indicated ☐ Exclude

Other Benefits and Amounts Requested, please explain: _____

Non-Occupational Accident:

Non-Occupational Accident Benefits: Included, unless otherwise indicated ☐ Exclude

NOTE: All coverage and benefits are subject to the terms and conditions in the policy.

INSURANCE BROKER INFORMATION

Name: _____ Agency: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Facsimile: _____ Email: _____

Standard Commission: ☐ Yes ☐ No ☐ Other _____%

INSURANCE PLAN INFORMATION

1. Are all Independent Contract Drivers required to have either workers' compensation or occupational accident coverage? ☐ Yes ☐ No
2. Who is the workers' compensation insurance carrier for employee exposure? _____
   a. Please indicate the retention or deductible amount: $_____
3. Will the trucking company settle deduct insurance premiums? ☐ Yes ☐ No
4. Why are you considering Zurich? _____

5. Please attach current policy and claim runs for the past three (3) years and complete the table below:

Coverage Period	Insurance Company	Premium	Total Losses	Monthly Rate	# of Drivers
to		$	$	$	
to		$	$	$	
to		$	$	$	

GENERAL INFORMATION

1. Number of years in business: _____
   Public or Privately Owned: _____
2. List states with terminal locations: _____
3. Number of independent contract drivers: _____
   Number of employee drivers: _____
   Number of non-driving employees: _____
4. On what basis are independent contract drivers compensated? _____
5. Annual independent contract driver turnover ratio: recent year _____ two (2) years ago _____
   (turnover ratio is defined as total number of independent contract drivers dispatched during the past twelve (12) months minus current number of contractors divided by current number of contractors)
6. Do you offer independent contract drivers: ☐ health insurance, ☐ physical damage, and/or ☐ NTL
7. Percentage of loads with manual loading/unloading (hand dolly/lift by hand)? _____
8. Do you administer "physical ability to perform" testing? ☐ Yes ☐ No If Yes, please describe: _____
9. Number of independent contract drivers over age 60? _____
10. Do independent contract drivers use casual labor, helpers or lumpers? ☐ Yes ☐ No If Yes, please describe: _____
11. What percentage of independent contract driver loads are Hazmat? _____%. Please describe: _____
12. What percentage of independent contract driver loads are LTL? _____%.
13. What percentage of independent contract driver loads are less than 200 miles? _____%
14. What is expected miles per year for independent contract drivers? _____
15. Date of most recent legal review of lease agreement? _____ Please attach a copy

Equipment:

Vehicles Used:	Box	Flatbed	Intermodal	Tanker	Refrigerated	Dump	Straight Truck	Other
% of total:	_____%	_____%	_____%	_____%	_____%	_____%	_____%	_____%

Commodities:

Describe: (1) _____ (2) _____ (3) _____ (4) _____
% of total: _____% _____% _____% _____%

SAFETY & LOSS CONTROL

1. Describe any OSHA fines related to driving/equipment in the past three (3) years: _____
2. Is there a full-time Safety Manager? ☐ Yes ☐ No If Yes:
   a. Name of Safety Manager: _____
   b. Number of years with Applicant: _____
   c. Number of years in loss prevention: _____
3. Is there a written safety plan applicable to independent contract drivers? ☐ Yes ☐ No If Yes, does it include the following:
   a. Requires reoccurring training? _____
   b. Driver incentives? _____
   c. Are safety inspections done in house or by an outside vendor? _____
4. Are physicals done by contracted doctors or driver's doctors? _____
5. Do you run MVRs? _____
6. Do you run background checks? _____
7. Do you do physical ability to perform testing? _____
8. Provide below minimum standards for hiring independent contract drivers:
   a. Minimum Age: _____

b. Maximum Age: _____
c. Minimum Prior CDL experience: _____
d. Maximum number of accidents permitted: _____ in past _____ years
e. Maximum number of violations permitted: _____ in past _____ years
f. Maximum number of major violations permitted: _____ in past _____ years
g. Describe any other criteria for qualifying independent contract drivers: _____

DRIVER CENSUS INFORMATION

Please complete the following or attach a list including state of residence and driver type:

Definitions:

Owner/Operator (OO) is an independent contractor who owns and drives the truck unit.
Contract Driver (CD) is an independent contractor who is paid on a 1099, but drives the truck for another owner.
Fleet Owner (FO) is an independent contractor who has more than one truck under contract to the trucking firm.
Fleet Driver (FD) * is a W-2 paid employee driver of a contracted fleet owner.

*** Fleet Drivers are not eligible for occupational accident coverage and must be covered under workers' compensation.**

State	OO	CD	FO	FD	State	OO	CD	FO	FD
Alabama					Montana				
Alaska					Nebraska				
Arizona					Nevada				
Arkansas					New Hampshire				
California					New Jersey				
Colorado					New Mexico				
Connecticut					New York				
Delaware					North Carolina				
D.C.					North Dakota				
Florida					Ohio				
Georgia					Oklahoma				
Hawaii					Oregon				
Idaho					Pennsylvania				
Illinois					Puerto Rico				
Indiana					Rhode Island				
Iowa					South Carolina				
Kansas					South Dakota				
Kentucky					Tennessee				
Louisiana					Texas				
Maine					Utah				
Maryland					Vermont				
Massachusetts					Virginia				
Michigan					Washington				
Minnesota					West Virginia				
Mississippi					Wisconsin				
Missouri					Wyoming				
Totals:	0	0	0	0		0	0	0	0

Owner/Operators: **0**
Contract Drivers: **0**
Fleet Owners: **0**
Fleet Drivers *: **0**

*** Fleet Drivers are not eligible for occupational accident coverage and must be covered under workers' compensation.**

INSURANCE FRAUD WARNING
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The applicant hereby applies for Occupational Accident Insurance and:

1. Represents that the answers included in this Application for Occupational Accident Insurance coverage have been reviewed and are true and complete; and
2. Understands and agrees that the insurance applied for shall not become effective until the Application for Occupational Accident Insurance coverage is approved by the **Company** and the initial premium deposit is received; and
3. Agrees that if the insurance applied for is approved by the **Company**, the applicant will pay all premiums due after the effective date of the insurance.

This Group Application shall be made part of the **Policy**, if issued.

Completed by: _____ Title: _____

Signature: _____ Date: _____

[Truckers] [Occupational] Accident Insurance Certificate

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

This is a summary of the accident insurance **We** provide on behalf of the **Policyholder** to **You** if **You** are within a class of eligible persons described in the **Schedule** and if the required premiums are paid when due.

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]

THE INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE ONLY. THE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

THIS IS A SUMMARY OF COVERAGE ONLY WHICH SUMMARIZES AND EXPLAINS THE PARTS OF THE POLICY WHICH APPLY TO YOU.

FOR ALL TERMS AND CONDITIONS OF COVERAGE, PLEASE REVIEW THE POLICY ISSUED TO THE POLICYHOLDER AND ON FILE WITH THEM AT THEIR PLACE OF BUSINESS. YOU CAN OBTAIN A COPY OF THE POLICY FROM THE POLICYHOLDER.

THIS CERTIFICATE IS NOT AN INSURANCE POLICY. IN THE EVENT OF A CONFLICT OF PROVISIONS BETWEEN THE POLICY AND THIS CERTIFICATE, THE PROVISIONS OF THE POLICY WILL GOVERN.

IMPORTANT NOTICE
THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.

PLEASE READ THIS CERTIFICATE CAREFULLY

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THIS CERTIFICATE IS NOT WORKERS' COMPENSATION AND DOES NOT REQUIRE PRE-AUTHORIZATION OF A PHYSICIAN FOR COVERED SERVICES OR TREATMENT. YOU MAY CONSULT US AT [1-888-889-5330] TO DETERMINE IF A SERVICE OR TREATMENT IS COVERED. WE CAN PROVIDE YOU WITH THE NAME AND ADDRESS OF A PHYSICIAN WHO IS A PREFERRED PROVIDER.

YOU CANNOT BE COVERED BY ANY OTHER OCCUPATIONAL ACCIDENT POLICY ISSUED BY **US**. IF **YOU** PAY PREMIUM BUT ARE NOT ELIGIBLE FOR COVERAGE OR DO NOT QUALIFY FOR BENEFITS UNDER THE **POLICY**, **WE** WILL REFUND ANY UNEARNED PREMIUM PAID IN ERROR.

SECTION I - SCHEDULE

Policy Effective Date: [01/01/09]
[**Policy Period**: [01/01/09] to [01/01/10]]
[Policy] Premium Due Date: [01/01/09]
Policy Number: [XXXXXX-XX]

Your Premium: [$0.00]

Policyholder: [Name of Trucking Company]
[Address]
[City, State, Zip]

Eligible Persons

You are eligible to become an **Insured Person** under the **Policy** if **You** meet the following criteria:

CLASS I: **Actively at Work Owner/Operator** who has enrolled for coverage under the **Policy**.
CLASS II: **Actively at Work Contract Driver** who has enrolled for coverage under the **Policy**.

Benefits Summary

	Occupational Injuries	**Non-Occupational Injuries**
☐ Accidental Death Benefit:		
Principal Sum*	[$50,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Survivor's Benefit:		
Principal Sum*	[$175,000.00]	[$7,500.00]
Monthly Benefit Percentage of **Principal Sum**	[1.0%]	[1.0%]
Monthly Benefit Amount	[$1,750.00]	[$1,750.00]
☐ Accidental Dismemberment Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accidental Paralysis Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accident Medical Expense Benefit:		
Commencement Period	[90 days]	[90 days]
Deductible Amount	[$0.00]	[$0.00]
Maximum Benefit Amount	[$1,000,000.00]	[$5,000.00]
Maximum Benefit Period	[104 weeks]	[52 weeks]
Dental Benefit Maximum	[$2,500.00]	[$1,000.00]
Lifetime **Maximum Benefit Amount**	[$1,000,000.00]	[$10,000.00]
Physical, Occupational, or Work Hardening Therapies	To a maximum-combined [36] visits	[N/A]
Ambulance for Medically Necessary Services	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**

	Occupational Injuries	Non-Occupational Injuries
Acupuncture Care and Chiropractic Care	[$1,000.00] per **Injury**	N/A
[Hernia Coverage]	[$10,000.00]	N/A
[Hemorrhoid Coverage]	[$10,000.00]	N/A
Mental and Nervous or Depressive Condition	1 visit per day to a maximum of [$25.00] per visit and [20] visits per **Accident**	N/A
[**Occupational Cumulative Trauma**]	[$20,000.00]	N/A
[**Occupational Disease**]	[$20,000.00]	N/A

☐ Temporary Total Disability Benefit:

Commencement Period	[90 days]	[90 days]
Waiting Period	[7 days]	[7 days]
Benefit Percentage	[70.0%]	[70.0%]
Minimum Weekly Benefit Amount	[$125.00]	[$125.00]
Maximum Weekly Benefit Amount	[$500.00]	[$500.00]
Maximum Benefit Period**	[104 weeks]	[12 weeks]
[**Maximum Benefit Period** for Hernia]	[90 days]	N/A
[**Maximum Benefit Period** for Hemorrhoid]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Disease**]	[90 days]	N/A

☐ Continuous Total Disability Benefit: ***

Waiting Period	[equals **Maximum Benefit Period** for **Temporary Total Disability**]	N/A
Benefit Percentage	[70.0%]	N/A
Minimum Weekly Benefit Amount	[$50.00]	N/A
Maximum Weekly Benefit Amount	[$500.00]	N/A
Maximum Benefit Amount	[$300,000.00]	N/A
Maximum Benefit Period	Up to age 70, but not beyond full Social Security retirement age	N/A

☐ Additional Benefits:

[Return of Remains Benefit]	[Refer to SECTION VI]	N/A
[Non-Medical Repatriation Benefit]	[Refer to SECTION VI]	N/A
[After School Care Benefit]	[Refer to SECTION VI]	N/A
[Coma Benefit]	[Refer to SECTION VI]	N/A
[Critical Burn Benefit]	[Refer to SECTION VI]	N/A
[Day Care Benefit]	[Refer to SECTION VI]	N/A
[Felonious Assault Benefit]	[Refer to SECTION VI]	N/A
[Higher Education Benefit]	[Refer to SECTION VI]	N/A
[Hijacking Benefit]	[Refer to SECTION VI]	N/A
[Vehicle Modification Benefit]	[Refer to SECTION VI]	N/A
[Seat Belt Benefit]	[Refer to SECTION VI]	N/A
[Spouse Retraining Benefit]	[Refer to SECTION VI]	N/A

Limits of Liability:

Combined Single Limit of Liability	[$1,000,000.00]	[$10,000.00]
Aggregate Limit of Liability	[$2,000,000.00]	[$15,000.00]
Sub Limits of Liability:		
[**Combined Single Limit of Liability** for:		
[Hernia]	[$20,000.00]	N/A

	Occupational Injuries	Non-Occupational Injuries
[Hemorrhoid]	[$20,000.00]	N/A
[**Occupational Disease**]	[$50,000.00]	N/A
[**Occupational Cumulative Trauma**]	[$50,000.00]	N/A

* Starting at age [65], the **Principal Sum** shall be based on the following schedule:

Age at Date of Loss	Percent of **Principal Sum**
[65]	[80%]
[66]	[60%]
[67]	[40%]
[68]	[20%]
[69]	[15%]
[70 and over]	[10%]

** If **You** suffer an **Injury** at or after age [70], the **Maximum Benefit Period** shall be [one (1) year].

*** If **You** sustain an **Injury** within six months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration, **You** do not qualify for the Continuous Total Disability Benefit.

SECTION II - GENERAL DEFINITIONS

Accident means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while coverage is in effect under the **Policy**.

Actively at Work means under **Dispatch** for at least [30] hours each week.

Aggregate Limit of Liability shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

Assignment means the **Policyholder** has offered and **You** have accepted a shipment of freight as recorded in the books and records of the **Policyholder** in the ordinary course of business.

Certificate means this [Truckers] [Occupational] Accident Insurance Certificate.

Company means Zurich American Insurance Company.

Co-Owner means a person who has partial ownership of a vehicle operating as an **Owner/Operator**.

Combined Single Limit of Liability means, with respect to **You**, the maximum amount that **We** will pay for all **Covered Loss** under the **Policy** for or in connection with **Injury** to **You** resulting from any one **Accident**. When the **Combined Single Limit of Liability** has been reached, no further benefits shall be payable under the **Policy**, with respect to **You**, for or in connection with **Injury** sustained as the result of that one **Accident**.

Commencement Period means the period between the date of the **Accident** that caused the **Injury** and the date on which the **Covered Loss** must occur for benefits to be payable under the Accidental Death Benefit, the Accidental Dismemberment Benefit, Accidental Paralysis Benefit, Accident Medical Expense Benefit and/or the Temporary Total Disability Benefit.

Contract Driver means an individual who:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [is authorized by an **Owner/Operator** to operate a power unit owned or leased by an **Owner/Operator** and must neither own nor lease the power unit;]
3. [is compensated on a basis other than time expended in the performance of work;]
4. [is responsible for determining the route and time for **Assignment**;]
5. [has the principal duty to operate the power unit;]

6. [is classified as an independent contractor by the **Policyholder** and the **Owner/Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance, or for any other purpose, [unless workers' compensation coverage is not mandatory for such person as an employee of either the **Policyholder** or **Owner/Operator**];] and
7. [receives for federal income tax reporting purposes a 1099 and not a W-2].

Covered Loss, in the singular or plural, means one or more of the losses or expenses identified in Sections V and VI of this **Certificate** that are not specifically excluded herein.

Cumulative Trauma or Repetitive Conditions means **Non-Occupational** conditions that impair the normal physiological function of the body over an extended period, but do not arise as the result of a single **Accident**.

Dependent Child(ren) means **Your** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption, who are:
1. under age 19 or under age 23 if he or she [:] [(a)] is enrolled in accredited institution of higher learning on a full-time basis, [and (b) relies on **You** for more than 50% of his or her support and is taken as a dependent on **Your** Federal Income Tax Return]; or
2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on **You** for support and maintenance as defined herein.

We may require proof of the **Dependent Child(ren)'s** incapacity and dependency before the **Dependent Child(ren)** reached the age limit specified above. **We** may request that satisfactory proof of the **Dependent Child(ren)'s** continued incapacity and dependency be submitted to **Us** on an annual basis.

Dispatch means the time during which **You** are on **Assignment** or **You** are performing tasks prior to or after an **Assignment** to prepare the contracted vehicle for a current or future **Assignment**. **Dispatch** must be authorized by the **Policyholder** and includes the following:
1. in route to pick up a load;
2. picking up a load;
3. in route to delivering a load;
4. unloading a load;
5. the waiting time for a load;
6. returning from delivering a load;
7. in route to, returning from or performing a pre-trip inspection as required by a recognized governmental agency and/or the contracted motor carrier;
8. [while performing vehicle maintenance or repairs on the contracted vehicle during any of the foregoing times; and]
9. [while performing verifiable vehicle maintenance or repairs on the contracted vehicle; and]
10. performing activities to comply with federal or state laws or to satisfy contracted motor carrier requirements.

Eligible Person(s) means a Class I or Class II individual described in the **Schedule**.

Household Member means a person who maintains residence at the same address as **You** and is not an **Immediate Family Member**.

Immediate Family Member means **Your Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, stepparent, brother, sister, stepbrother, stepsister, child, child who has been legally adopted, or stepchild.

Injury, in the singular or plural, means bodily injury caused by an **Accident**, which occurs while **You** are covered under the **Policy** and the **Injury** must result directly and independently of all other causes, in a **Covered Loss**. All **Injuries** sustained by **You** in any one **Accident** shall be considered a single **Injury**.

Insured Person(s) means an **Owner/Operator** or **Contract Driver**:
1. who is enrolled for coverage under the **Policy**;
2. who has paid the required premium when due; and
3. whose coverage is in effect under the **Policy**.

Maximum Benefit Amount means the maximum amount that **We** will pay under the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Amount** is shown in the **Schedule**.

Maximum Benefit Period means the maximum period that **We** will pay benefits, after the **Waiting Period**, under the Temporary Total Disability Benefit, the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Period** is shown in the **Schedule**.

Maximum Weekly Benefit Amount means the maximum amount that **We** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Maximum Weekly Benefit Amount** is shown in the **Schedule**.

Mental and Nervous or Depressive Condition means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.

Minimum Weekly Benefit Amount means the minimum amount that **We** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Minimum Weekly Benefit Amount** is shown in the **Schedule**.

Non-Occupational means benefits payable for an **Injury** due to an **Accident** sustained by **You** while not under **Dispatch**.

Occupational means, with respect to an activity, **Accident**, incident, circumstance or condition involving **You**, that the activity, **Accident**, incident, circumstance or condition occurs or arises out of or in the course of **You** performing services within the course and scope of contractual obligations for the **Policyholder**, and while under **Dispatch**. **Occupational** does not encompass any period during the course of everyday travel to and from work, other than as allowed under **Dispatch**, or while on vacation.

Occupational Assessment means a test of vocational capabilities, including review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), and evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

Occupational Cumulative Trauma means bodily injury that impairs the normal physiological function of the body caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time and does not arise as the result of a single **Accident**, when:
1. such condition is diagnosed by a **Physician**;
2. **Your** last day of last performance of the activities causing the bodily injury occurred while **Your** coverage is in effect; and
3. such bodily injury resulted directly, and independently of all other causes, in a **Covered Loss**.

Occupational Disease means a sickness that results in disability or death, and is caused by exposure to environmental or physical hazards during the course of **Your Occupational** activities, when:
1. such sickness is diagnosed by a **Physician** and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards;
2. exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which **You** perform **Occupational** activities;
3. **Your** last day of last exposure to the environmental or physical hazards causing such sickness occurs while **Your** coverage is in effect; and
4. such exposure results directly and independently of all other causes in a **Covered Loss**.

Owner/Operator means an individual who leases to or from the **Policyholder** and:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [owns or leases a power unit;]
3. [is responsible for the maintenance and operating costs of the power unit, including, but not limited to fuel, repairs and supplies;]
4. [is compensated on a basis other than time expended in the performance of work;]
5. [is responsible for determining the route and time for **Assignment**;]
6. [has the right to select or reject the load;]
7. [has a written contract or **Assignment** from the **Policyholder** and is classified as an independent contractor by the **Policyholder** and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;] and

8. [receives for federal income tax reporting purposes a 1099 not a W-2].

Physician means a qualified medical doctor acting within the scope of his or her license who is not:
1. **You**;
2. an **Immediate Family Member**;
3. a **Household Member**; or
4. a practitioner retained by the **Policyholder**.

Policy means the [Truckers] [Occupational] Accident Insurance Policy issued to the **Policyholder**.

Policyholder means the entity named as **Policyholder** in the **Schedule**.

Policy Period means the period shown in the **Schedule**, subject to prior termination pursuant to Section III of the **Policy**.

Pre-Existing Condition means a condition for which **You** have sought or received medical advice or treatment at any time during the twelve months immediately preceding **Your** effective date of coverage under the **Policy**.

Principal Sum means the maximum amount that **We** will pay under the Accidental Death Benefit, the Survivor's Benefit, the Accidental Dismemberment Benefit or the Accidental Paralysis Benefit. The applicable **Principal Sum** is shown in the **Schedule** and is subject to the **Combined Single Limit of Liability** and the **Aggregate Limit of Liability**.

Schedule means SECTION I of the **Policy** and this **Certificate**.

Spouse means **Your** legal spouse.

Third Party in the singular or plural means, but is not limited to, the following:
1. the party that caused the **Accident**, **Injury** or other medical condition and any insurer or indemnifier thereof;
2. **Your** insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers; or
3. any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the **Accident**, **Injury** or other medical condition.

Waiting Period means the consecutive number of days **You** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Policy**. Temporary Total Disability Benefits and Continuous Total Disability Benefits are [not] retroactive to the first day of disability. The **Waiting Period** is shown in the **Schedule**.

We, **Us**, and **Our** means Zurich American Insurance Company.

You, **Your**, and **Yourself** means the **Insured Person** to whom a **Certificate** is issued.

SECTION III - EFFECTIVE DATES AND TERMINATION DATES

Policy Effective and Termination Dates

1. Policy Effective Date. The **Policy** begins on the Policy Effective Date shown in the **Schedule** at 12:01 A.M. Standard Time at the address of the **Policyholder** where the **Policy** is delivered.

2. Policy Termination Date. The **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of:
   a. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   b. the date specified in the written notice of **Our** intent to terminate the **Policy**, which will be at least [thirty (30)] days after the date **We** send such notice to the **Policyholder's** last known recorded address;
   c. the date specified in the written notice of the **Policyholder's** intent to terminate the **Policy**, which will be at least [thirty (30)]days after the date the **Policyholder** sends such notice to **Us**; or
   d. at the expiration of the **Policy Period**.

   If **We** terminate the **Policy**, any unearned premium will be returned on a pro-rata basis. If the **Policyholder** requests termination, **We** will return any unearned premium paid on a pro-rata basis. Termination will not affect any claim for a **Covered Loss** occurring prior to the effective date of termination.

Owner/Operator's Effective and Termination Dates

1. **Owner/Operator's** Effective Date. An **Owner/Operator's** coverage under the **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Owner/Operator** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Owner/Operator's** Termination Date: An **Owner/Operator's** coverage under the **Policy** ends on the earliest of:
   a. the date the **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   c. the date the **Owner/Operator** requests, in writing, that his or her coverage be terminated; or
   d. the date the **Owner/Operator** ceases to be an **Insured Person**.

Contract Driver's Effective and Termination Dates

1. **Contract Driver's** Effective Date. A **Contract Driver's** coverage under the **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Contract Driver** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Contract Driver's** Termination Date. A **Contract Driver's** coverage under the **Policy** ends on the earliest of:
   a. the date the **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   c. the date the **Contract Driver** requests, in writing, that his or her coverage be terminated;
   d. the date the **Contract Driver** ceases to be an **Insured Person**; or
   e. the date the **Owner/Operator**, with whom the **Contract Driver** is under contract, ceases to be an **Insured Person** and/or whose contract with the **Policyholder** terminated.

A change in **Your** coverage under the **Policy** due to a change in **Your** eligible class or benefit selection becomes effective on the later of: (1) the date the change in **Your** eligible class or benefit selection occurs; or (2) if premium change is required, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

SECTION IV - PREMIUMS

PREMIUMS

Premiums are payable to **Us** in the amount shown in the **Schedule**. **We** may change the required premiums due by giving the **Policyholder** at least [sixty (60) days] advance written notice. **We** may change the required premiums as a condition of any renewal of the **Policy**. **We** may also change the required premiums at any time when any change affecting premiums is made in the **Policy**.

We may re-underwrite and may change the terms and conditions of the **Policy** including the premium rate on the date when the number of **Insured Persons** under the **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [fifteen percent (15%)] or more. The **Policyholder** shall provide **Us** with written notice of such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.

PLAN AND EXPOSURE CHANGES

The **Policyholder** must notify **Us** of any subsidiary or affiliated company that is to be covered under the **Policy**. Such notice must be sent within [thirty (30) days] of the acquisition of such subsidiary or affiliated company. If such notice is not

provided, the newly acquired entity will not be considered a part of the **Policyholder** and the owner/operators or contract drivers will not be **Insured Persons** until the date that notice is provided. **We** have the right to decline coverage or adjust premium based on the changing exposure.

YOUR PREMIUM
Your Premium is shown in the **Schedule** and shall be payable as follows:
1. if **You** enroll on or prior to the fifteenth (15th) day of the month, **You** shall pay an amount equal to the full monthly premium. No premium shall be payable for the last full or partial month of coverage; and
2. if **You** enroll after the fifteenth (15th) day of the month, **You** shall pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, **You** shall pay an amount equal to the monthly premium.

YOUR GRACE PERIOD
A grace period of [thirty-one (31) days] will be provided for the payment of **Your** Premium due after the first premium. **Your** coverage will not be terminated for non-payment of premium during this grace period if **You** pay the premium due by the last day of this grace period. **Your** coverage will terminate if the full amount of the premium due is not paid by the last day of this grace period.

POLICY GRACE PERIOD
A grace period of [thirty-one (31)] days will be provided for the payment of any premium due after the first premium. The **Policy** will not be terminated for nonpayment of premium during this grace period if the **Policyholder** pays all premiums due by the last day of this grace period. The **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of this grace period. No Policy Grace Period will be provided if **We** receive notice to terminate the **Policy** prior to a premium due date.

If **We** expressly agree to accept late payment of a premium without terminating the **Policy**, **We** do so in accordance with the Noncompliance With Policy Requirements provision in Section X of the **Policy**. In such case, the **Policyholder** will be liable to **Us** for any unpaid premiums for the time the **Policy** is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by **Us** in the collection of all overdue amounts.

WAIVER OF PREMIUM
During the period in which **You** are receiving a Temporary Total Disability Benefit or Continuous Total Disability Benefit, premiums will be waived from the first premium due date on or after the benefit begins to the premium due date following the date the benefit ceases, at which time premium payments must resume. If premium payments are not resumed on that date, **Your** coverage under the **Policy** shall terminate on that date. **You** are responsible for reporting Waiver of Premium to the **Policyholder** or an authorized person designated by the **Policyholder** or **Us**.

SECTION V - BENEFITS

ACCIDENTAL DEATH BENEFIT
If **Injury** to **You** results in death within the **Commencement Period**, **We** will pay the **Principal Sum** to the beneficiary in accordance with the Payment of Claims provision in Section IX of the **Certificate**.

SURVIVOR'S BENEFIT
If an Accidental Death Benefit is payable under the **Policy**, **We** will pay the **Monthly Benefit Amount**, up to the **Principal Sum**, to **Your** surviving **Spouse**.

If **You** are not survived by a **Spouse**, or if **Your Spouse** dies or remarries, **We** will pay or continue to pay the Survivor's Benefit to **Your** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. Payment of the **Monthly Benefit Amount** will end on the earliest of the following:
1. the date **Your Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date **Your** last **Dependent Child** dies or is no longer a **Dependent Child**; or
3. the date the **Principal Sum** has been paid.

If **You** are not survived by a **Spouse** or any **Dependent Child(ren)**, **We** will not pay a Survivor's Benefit.

For this benefit, the following definition applies:

Monthly Benefit Amount means the product of the Monthly Benefit Percentage shown in the **Schedule** multiplied by the **Principal Sum**.

EXPOSURE AND DISAPPEARANCE BENEFIT
If **You** are exposed to weather because of an **Accident**, which results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If **Your** body has not been found within one year after **Your** disappearance, stranding, sinking or wrecking of a power unit in which **You** were an occupant, then it will be presumed, subject to all other terms and provisions of the **Policy**, that **You** have suffered Accidental Death within the meaning of the **Policy**. If **You** are found and identified, **We** have the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT
If **Injury** to **You** results in any one of the **Losses** specified below within the **Commencement Period**, **We** will pay the Percentage of the **Principal Sum** shown below:

For **Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	[100%]
Sight of Both Eyes	[100%]
One Hand and One Foot	[100%]
One Hand and the Sight of One Eye	[100%]
One Foot and the Sight of One Eye	[100%]
One Hand or One Foot	[50%]
Sight of One Eye	[50%]
Thumb and Index Finger of Same Hand	[25%]
Speech and Hearing	[50%]
Speech or Hearing	[25%]

If more than one **Loss** is sustained by **You** as a result of the same **Accident**, only one amount, the largest, will be paid.

For this benefit, the following definition applies:

Loss, in the singular or plural, of a hand or foot means complete severance through or above the wrist or ankle joint; **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye; and **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

PARALYSIS BENEFIT
If **Injury** to **You** results in any Type of Paralysis specified below within the **Commencement Period**, **We** will pay the Percentage of the **Principal Sum** shown below:

Type of Paralysis:	Percentage of the **Principal Sum**
Quadriplegia	[100%]
Paraplegia	[75%]
Hemiplegia	[50%]
Uniplegia	[25%]

If **You** sustain more than one Type of Paralysis as a result of the same **Accident**, only the largest single amount will be considered a **Covered Loss**.

For this benefit, the following definitions apply:

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**.

Paraplegia means the complete and irreversible paralysis of both lower **Limbs**.

Hemiplegia means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body.

Uniplegia means the complete and irreversible paralysis of one **Limb**.

Limb, in the singular or plural, means entire arm or entire leg.

TEMPORARY TOTAL DISABILITY BENEFIT

If **Injury** to **You** results in **Temporary Total Disability** within the **Commencement Period** and **You** are under age [70] on the day the **Temporary Total Disability** begins, **We** will pay the following amount, after the **Waiting Period**:

1. for each week of a **Temporary Total Disability** during a **Single Period of Total Disability** the Temporary Total Disability Benefit is equal to the lesser of:
   a. the Benefit Percentage shown in the **Schedule** of the **Average Weekly Earnings**; or
   b. the **Maximum Weekly Benefit Amount**;
2. for less than a full **Benefit Week** of **Temporary Total Disability**, the Temporary Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. the date **You** are no longer **Temporarily Totally Disabled**;
2. the date **You** die;
3. the date the **Maximum Benefit Period** has been reached; or
4. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**.

For this benefit, the following definitions apply:

Average Weekly Earnings means:

1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income **You** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [thirty-three percent (33%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income **You** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [seventy-five percent (75%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [seventy-five percent (75%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation provided **You** were not an **Owner/Operator**. If **You** were an **Owner/Operator**, then **We** will use 33% of the gross income.]

You must produce proof of **Your** gross income and the number of weeks worked. Otherwise, **We** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the **Maximum Weekly Benefit Amount**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the first day of **Temporary Total Disability** after the **Waiting Period** and on the same day of each week thereafter.

Continuous Care means monthly monitoring or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Temporary Total Disability** on a monthly basis.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following, which are considered separate periods of disability:
1. successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which **You** are not **Temporarily Totally Disabled**; or
2. successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least six (6) months during which **You** are not **Temporarily Totally Disabled**.

Temporary Total Disability or Temporarily Totally Disabled means disability that:
1. prevents **You** from performing the **Material and Substantial Duties** of **Your** occupation [as a commercial truck driver];
2. requires the care and treatment of a **Physician**; and
3. requires that and results in **Your** receiving **Continuous Care**.

If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** shall not qualify for the Temporary Total Disability Benefit. During this period, **You** cannot engage in any activity which results in earned income.

Material and Substantial Duties means a duty or duties which **You** are required to perform under the terms of the written contract with the **Policyholder** or **Owner/Operator** and as described in **Your** application.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Temporary Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which **Your** dependents may qualify because of **Your** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; and
4. the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

You must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

CONTINUOUS TOTAL DISABILITY BENEFIT
If **Injury** to **You** resulting in **Temporary Total Disability** subsequently results in **Continuous Total Disability**, **We** will pay the following, after the **Waiting Period**:
1. for each month of a **Continuous Total Disability**, the Continuous Total Disability Benefit is four and three-tenths (4.3) times the **Weekly Benefit Amount** for **Temporary Total Disability**; or
2. for less than a full **Benefit Week** of **Continuous Total Disability**, the Continuous Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Continuous Total Disability**, but only if:
    a. Temporary Total Disability Benefits ceased solely because the **Maximum Benefit Period** has been reached, but **You** remain disabled;
    b. **You** are not within six (6) months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration, on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached;
    c. **You** have been granted a Social Security disability award for **Your** disability (if **You** cannot meet the credit requirement for a Social Security disability award **You** cannot qualify for the Continuous Total Disability Benefit even if **You** would otherwise qualify);
    d. **Your** disability is reasonably expected to continue without interruption until **You** die and is substantiated by objective medical evidence satisfactory to **Us**;
    e. the **Injury** resulting in a **Continuous Total Disability** occurred before **You** are within six (6) months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration; [and]

f. the **Injury** began within the **Commencement Period** [.] [; and]
g. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**.]

The Continuous Total Disability Benefit shall cease on the earliest of the following:
1. the date **You** are no longer **Continuously Totally Disabled**;
2. the date **You** die;
3. the date **Your** Social Security disability award ceases;
4. the date the **Maximum Benefit Period** has been reached;
5. the date that the **Maximum Benefit Amount** has been paid; or
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**.

For this benefit, the following definitions apply:
Average Weekly Earnings will be calculated as follows:
1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income **You** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [thirty-three percent (33%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income **You** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [seventy-five percent (75%)] of the average gross income received by the other **Insured Persons**, who were contracted within the last three (3) months prior to the covered **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [seventy-five percent (75%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation provided **You** were not an **Owner/Operator**. If **You** were an **Owner/Operator**, then **We** will use 33% of the gross income.]

You must produce proof of **Your** gross income and the number of weeks worked. Otherwise, **We** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the Maximum Weekly Benefit. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Total Disability or Continuously Totally Disabled means disability that:
1. prevents **You** from performing the duties of any occupation for which **You** are qualified by reason of education, training or experience;
2. requires the care and treatment of a **Physician**; and
3. requires that, and results in, **Your** receiving **Continuous Care**.

We must receive proof of continuing **Continuous Total Disability** on a quarterly basis; provided however, that **We** may waive requirements 2 and 3. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** shall not qualify for **Continuous Total Disability**. During this period, **You** cannot engage in any activity which results in earned income.

Continuous Care means at least quarterly monitoring or evaluation of the disabling condition by a **Physician**.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Continuous Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which **Your** dependents may qualify because of **Your** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; or
4. the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

You must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

ACCIDENT MEDICAL EXPENSE BENEFIT
If **You** suffer an **Injury** requiring treatment by a **Physician** within the **Commencement Period**, **We** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Services or Charges** received or incurred due to such **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** for all **Injuries** caused by a single **Accident**, subject to any applicable **Deductible Amount**.

For this benefit, the following definitions apply:
Ambulatory Medical Center means a facility that:
1. operates under the laws of the state in which it is situated;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility.

Ambulatory Medical Center does not include a **Hospital**, **Physician's** office or clinic.

Custodial Services means any services which are not intended primarily to treat a specific injury. **Custodial Services** include, but shall not be limited to, services:
1. related to watching or protecting **You**;
2. related to performing or assisting **You** in performing any activities of daily living, such as:
   a. walking;
   b. grooming;
   c. bathing;
   d. dressing;
   e. getting in or out of bed;
   f. toileting;
   g. eating;
   h. preparing foods; or
   i. taking medications that can usually be self-administered; and
3. that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment means equipment of a type that is designed primarily for use by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a spa or a stationary bicycle).

Deductible Amount means the total amount of **Medically Necessary Services or Charges** that must be paid by **You** before any Accident Medical Expense Benefit is paid under the **Policy**. **We** shall not be responsible for any **Medically Necessary Services or Charges** within the **Deductible Amount** as set forth in the **Schedule**.

Extended Care Facility means an institution that meets all of the following requirements:
1. operates under the laws of the state that it is situated in;
2. is approved by the United States Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a registered nurse;
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment of **You** in **Your** home as part of a treatment plan prescribed by the attending **Physician**, which is provided by a **Hospital** or agency certified to provide such services, but only if it:

1. begins within [seven (7)] days after discharge from a **Hospital**; and
2. follows a **Hospital** confinement of [five (5)] days or more.

Hospital means a facility that:
1. operates under the law of the state in which it is situated;
2. is approved by the United States Department of Health and Human Services or its successor;
3. has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
4. has 24-hour nursing service by registered nurses on duty or on call; and
5. is supervised by one or more **Physicians**.

A **Hospital** does not include:
1. a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care;
2. a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, or any ward, room, wing or other section of a hospital that is used for such purposes; or
3. any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Medically Necessary Services or Charges means one or more of the following, but only if each: (a) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (b) meets generally accepted standards of medical practice; and (c) is ordered by a **Physician** and performed under his or her care, supervision or order:
1. **Hospital** room and board charges or room and board charges in an intensive care unit; **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room); use of an **Ambulatory Medical Center**; and **Hospital** charges for in-patient treatment of a **Mental and Nervous or Depressive Condition**, as shown in the **Schedule**;
2. treatment by a **Physician** of a covered **Mental and Nervous or Depressive Condition** due to an **Injury**, as shown in the **Schedule**;
3. Ambulance service to or from a **Hospital**, as shown in the **Schedule**;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. Physical, Occupational or Work Hardening Therapies, Chiropractic Care and Acupuncture, as shown in the **Schedule**;
9. **Durable Medical Equipment** rental charges, up to the actual purchase price of such equipment;
10. the initial supply, but not any replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes;
11. medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
12. repair or replacement of **Sound Natural Teeth** damaged or lost as a result of **Injury**, up to the Dental Benefit Maximum, if any, shown in the **Schedule**;
13. **Extended Care Facility**; or
14. **Home Health Care**.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary Services or Charges** for the care and treatment of the **Injury**, including but not limited to: (1) a non-essential private **Hospital** room; (2) television rental; and (3) **Hospital** telephone charges.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary Charge(s) means an amount(s) that:
1. does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and
2. does not include charges that would not have been made if no insurance existed[; and
3. does not exceed the cost of a generic drug, if available. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available].

ACCIDENT MEDICAL EXPENSE BENEFIT EXCLUSIONS
In addition to the General Exclusions and Limitations in Section VIII of the **Policy**, **Medically Necessary Services or Charges** do not include expenses for or resulting from any of the following:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
2. dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. eye glasses or contact lenses;
4. hearing aids or hearing examinations;
5. rental of **Durable Medical Equipment** if the total rental expense exceeds the usual purchase price for similar equipment in the locality where the expense is incurred, unless authorized by **Us**;
6. **Custodial Services**;
7. **Personal Comfort or Convenience Items**;
8. services of any government **Hospital** for which **You** are not liable for payment;
9. any expenses covered by [Medicare, Medicaid,] a **Third Party** [or any other insurance];
10. expenses incurred which are more than the **Usual and Customary Charge**;
11. cosmetic, plastic or restorative surgery unless otherwise covered;
12. expenses which **You** are not legally obligated to pay;
13. an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;
14. any mileage costs or lodging expenses, unless authorized by **Us**;
15. any translation costs, unless authorized by **Us**; or
16. **Home Health Care** services provided by an **Immediate Family Member** or **Household Member**.

SECTION VI - ADDITIONAL BENEFITS

[**RETURN OF REMAINS BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay for the transport of **Your** body or remains (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of **Your** body or remains to **Your** county of residence. **We** must be contacted prior to the transportation of **Your** body or remains and **We** must pre-authorize the transportation for coverage to apply. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**NON-MEDICAL REPATRIATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accident Medical Expense Benefit and have sufficiently recovered to travel in a regularly scheduled economy class air flight, commercial bus or train and without special medical equipment or personnel with a minimal risk to **Your** health, **We** will pay for the return to **Your** principal residence. **We** must be contacted prior to the transport and **We** must agree to the travel itinerary for coverage to apply. This benefit is subject to the prior recommendation of the attending **Physician**. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**AFTER SCHOOL CARE BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit for after school care to the individual who incurs the expense on behalf of each **Dependent Child** who is [ten (10)] years old or less, up to a maximum of the lesser of:
1. [two percent (2%)] of the applicable **Principal Sum** paid under the Accidental Death Benefit per year; or
2. [two thousand dollars ($2,000)] per year.

The after school care provider may not be an **Immediate Family Member** and written proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, to establish continued eligibility for this benefit.

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child** is under age [ten (10)] at the time of each payment. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**COMA BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** and within three hundred sixty-five (365) days of the **Accident** which caused such **Injury**, such **Injury** causes **You** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay an

additional benefit equal to [one percent (1%)] of the **Principal Sum** for such **Injury**, and such amount will be paid each month **You** remain in a **Coma** following the initial thirty-one (31) day period. At the end of eleven (11) months of payment, if **You** remain in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the eleven (11) months of benefit already received.

The Coma Benefit will end on the earliest of the following:
1. the date **You** are no longer in the **Coma**; or
2. the date **You** have received a Coma Benefit for eleven (11) months.

We may require receipt of written proof, at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Coma means a condition determined as such by **Our** duly licensed **Physician**.]

[**CRITICAL BURN BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss**, **We** will pay an additional benefit equal to the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)], but only if **You**:
1. suffered second degree or higher burns over [twenty-five percent (25%)] of **Your** body; and
2. have undergone reconstructive surgery to treat the burned areas of **Your** body within three hundred sixty-five (365) days of the occurrence of the **Accident** that caused the **Injury**.]

[**DAY CARE BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense for each **Dependent Child** if:
1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and
2. the **Dependent Child** is under age [thirteen (13)].

The Day Care Benefit will be equal to the lesser of:
1. the actual cost of the day care;
2. [three percent (3)%] of the **Principal Sum**; or
3. [three thousand dollars ($3,000)];

and will be paid annually for [four (4)] consecutive years if:
1. the **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. written proof acceptable to **Us** is received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Accredited Child Care Facility means a properly licensed childcare facility that operates pursuant to state and local laws and has a Tax Identification Number issued by the Internal Revenue Service. **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**FELONIOUS ASSAULT BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** for an **Occupational Injury** payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Paralysis Benefit as a result of a **Felonious Assault** by someone other than **Yourself**, **You** or an **Immediate Family Member** or **Household Member**, **We** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum**, but only if:
1. the **Felonious Assault** occurs while **You** are under **Dispatch**; and
2. the crime directly involves the **Policyholder's** or **Your** funds or assets.

For this benefit, the following definition applies:

Felonious Assault means the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]

[**HIGHER EDUCATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay a benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**, but only if on the date of the **Accident**, the **Dependent Child**:

1. is enrolled as a full-time student in an accredited college, university or trade school; or
2. is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The Higher Education Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit for all **Dependent Child(ren)** combined is [twenty thousand dollars ($20,000)].]]

[**HIJACKING BENEFIT**
The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions and Limitations of the **Policy** is modified and an **Injury** directly resulting from a **Hijacking** or any attempt at any **Hijacking** is covered under the **Policy**.

This benefit will continue beyond the actual **Hijacking** while **You** are:

1. subject to the control of the person(s) making the **Hijacking**; and
2. traveling directly to **Your** home or original destination.

For this benefit, the following definition applies:

Hijacking means the unlawful seizure or wrongful exercise of control of a power unit occupied by **You**, while **You** are getting into, riding in, or getting out of and while under **Dispatch**.]

[**VEHICLE MODIFICATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Dismemberment Benefit or Paralysis Benefit, **We** will pay an additional benefit equal to the actual cost for modifications to **Your** motor vehicle that are necessary to make it accessible or drivable, but only if such **Injury** requires **You** to use a wheelchair. Benefits are not payable unless:

1. the modifications are made by a person(s) experienced in such modifications and are recommended by an organization recognized for providing support and assistance to wheelchair users; and
2. proof sufficient to **Us** is received by **Us**, establishing eligibility for this benefit.

The maximum amount payable under this benefit will be the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)].]

[**SEAT BELT BENEFIT**
If **You** suffer an **Injury** directly resulting from an automobile **Accident** resulting in a **Covered Loss** payable under the Accidental Death Benefit or Survivor's Benefit, **We** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum** up to a maximum of [ten thousand dollars ($10,000)], but only if **You** were:

1. operating or riding as a passenger in a motorized vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Accident**.

Your actual use of the seat belt or lap and shoulder restraints must be verified in the official law enforcement report of the **Accident**, through certification by the investigating officers; or by other reasonable proof, acceptable to **Us**.]

[**SPOUSE RETRAINING BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit to **Your Spouse** for the actual cost of any state licensed professional or trade-training program in which **Your Spouse** enrolls and completes, but only if the purpose of the program is to obtain an independent source of support and maintenance and the actual cost is incurred within [thirty (30)] months from **Your** death.

The Spouse Retraining Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if **Your Spouse** continues his or her training. Before this benefit is paid each year, proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit is [twenty thousand dollars ($20,000)].]

SECTION VII - LIMITS OF LIABILITY

The **Combined Single Limit of Liability** shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Loss** with respect to **You** arising out of **Injury** sustained by **You** as the result of any one **Accident** or Occurrence. The term Occurrence means a single event or related events or originating cause occurring within a 24-hour period.

The **Aggregate Limit of Liability** shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

If either the **Combined Single Limit of Liability** or the **Aggregate Limit of Liability** is not enough to pay all **Covered Loss**, **We** will pay reduced benefit amounts based upon the proportion that the **Covered Loss** bears to each benefit or expected total benefits that would otherwise be payable. If the total benefits are unknown, **We** will determine the total expected benefits for **You**.

Limitation on Multiple **Covered Loss**. If **You** suffer more than one **Covered Loss** under one benefit as a result of the same **Accident**, **We** will pay only up to the largest **Covered Loss** amount.

Limitation on Multiple Benefits. If **You** can recover benefits under two or more of the Accidental Death Benefit, Accidental Dismemberment Benefit, [Coma Benefit] or the Accidental Paralysis Benefit as a result of the same **Accident**, **We** will pay only up to the highest applicable **Principal Sum**.

SECTION VIII - GENERAL EXCLUSIONS AND LIMITATIONS

The **Policy** does not cover any losses contributed to or caused by, in whole or in part, by any of the following:

1. [suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** or any **Injury** resulting from a provoked attack;]
2. [sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning [or routine and temporary non chronic sickness or illness such as a cold, cough, headache or nausea];]
3. [a **Pre-existing Condition**, until **You** have been continuously covered under the **Policy** for [twelve (12)] consecutive months;]
4. [**Occupational Cumulative Trauma** or **Cumulative Trauma and Repetitive Conditions**, unless shown in the **Schedule**;]
5. [**Occupational Disease**, unless shown in the **Schedule**;]
6. [performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;]
7. [declared or undeclared war, or any act of declared or undeclared war;]
8. [full-time active duty in the armed forces of any country or international authority;]

9. [any **Injury** for which **You** are entitled to benefits pursuant to any workers' compensation law or other similar legislation;]
10. [any loss insured by employers' liability insurance;]
11. [**You** being intoxicated:
    a. **You** are conclusively deemed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether **You** are in fact operating a motor vehicle when the **Injury** occurs; and
    b. an autopsy report from a licensed medical examiner, law enforcement officer reports or similar items will be considered proof of **Your** intoxication;]
12. [**You** being under the influence of any illegal substance, drug, narcotic, or hallucinogen, unless such drug, narcotic, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage;]
13. [**Your** commission of or attempt to commit a felony or a Class A misdemeanor;]
14. [travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if **You** are:
    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or **You**;]
15. [skydiving, parasailing, hang-gliding, bungee-jumping [or any similar activity];] [or]
16. [charges incurred for treatment of a covered **Injury**, when **You** obtain compensation for the covered **Injury** from a **Third Party**].

[INCARCERATION LIMITATION
Benefits provided to **You** will cease while **You** are incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when **You** are released from such facility.]

SECTION IX - CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be received by **Us** within twenty (20) days after **Your** loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to **Us** at Zurich American Insurance Company Group Accident Claims Division, [P.O. Box 968041 Schaumburg, IL 60196] with information sufficient to identify **You**, is deemed notice to **Us**.

CLAIM FORMS
We will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within thirty (30) days after the giving of notice, the claimant will be deemed to have met the Proof of Loss requirements upon submitting, within the time fixed in the **Policy** for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include **Your** name, the **Policyholder's** name and the Policy Number.

PROOF OF LOSS
Written Proof of Loss acceptable to **Us** must be received by **Us** within ninety (90) days after the date of the loss. If the loss is one for which the **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proof acceptable to **Us** must be received by **Us**, at such intervals as **We** may reasonably require, establishing continued eligibility for the benefit. Failure to furnish such proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time such proof is otherwise required. **We** have a right to investigate any documents that **You** shall make available to **Us** upon request.

PAYMENT OF CLAIMS
Upon receipt of written proof of death, payment for loss of life of **You** will be made to **Your** beneficiary or, if there is no beneficiary designated, **Your** survivors in the following order:
1. **Your Spouse**;
2. **Your** child(ren);
3. **Your** parents;
4. **Your** brothers and sisters;
5. **Your** estate.

Upon receipt of written Proof of Loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) **You**. If **You** die before all payments due have been made, the amount still payable will be paid to **Your** beneficiary or, if there is no beneficiary designated, **Your** survivors in the order as listed above.

BENEFICIARY DISIGNATION AND CHANGE
Your designated beneficiary(ies) is (are) the person(s) so named by **You** as shown on the **Policyholder's** records kept on the **Policy**.

A legally competent **Insured Person** over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the **Policyholder** with a written request for change. When the request is received by the **Policyholder**, whether the **Insured Person** is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to **Us** on account of any payment which is made prior to receipt of the request.

Except for the Survivor's Benefit, if there is no designated beneficiary or no designated beneficiary is living after **Your** death, payment will be made to **Your** estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding one thousand dollars ($1,000) may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

We shall pay benefits directly to any **Hospital** or person rendering covered services, unless **You** request otherwise in writing and provides proof that payment was made directly to such **Hospital** or person. Such request must be made no later than the time Proof of Loss is filed. Any payment **We** make in good faith fully discharges **Our** liability to the extent of the payment made.

TIME OF PAYMENT OF CLAIM
Benefits payable under the **Policy** for any loss other than loss for which the **Policy** provides any periodic payment will be paid within thirty (30) days upon **Our** receipt of written Proof of Loss. Benefits payable periodically under the **Policy** will be paid at four (4) week intervals during the continuance of the period for which **We** are liable, subject to **Our** receipt of written Proof of Loss, and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

REHABILITATION
We will consider paying for a rehabilitation program for **You** based on an **Occupational Assessment** provided **You** are receiving benefits under either the **Temporary Total Disability Benefit** or the **Continuous Total Disability Benefit**. The rehabilitation program must be mutually agreed upon by **You** and **Us**. The extent of **Our** participation will be determined solely by **Us**. Any benefits payable will continue during **Your** rehabilitation unless otherwise agreed to by **Us**.

SUNSET
In no event shall benefits under the **Policy** be payable unless written Proof of Loss is received by **Us** within [three (3) years] from the date of the **Accident**.

[**ARBITRATION**
Any contest to a claim denial under the **Policy** shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration shall occur at the offices of the American Arbitration Association nearest to **You** or the person claiming to be the beneficiary. The arbitrator(s) shall not award consequential or punitive damages in any arbitration under this section. This provision does not apply if **You** or the person claiming to be the beneficiary is a citizen of a state where the law does not allow binding arbitration in an insurance policy but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. [Non-binding arbitration is required and no legal action may be brought by **You**, the beneficiary, or Us until thirty (30) days after the arbitrator(s) issues a non-binding award.] This provision bars the institution of any individual or class action lawsuit brought by **You** or the beneficiary.]

SECTION X - GENERAL PROVISIONS

ENTIRE CONTRACT
The **Policy**, together with any riders, endorsements, amendments, applications, enrollment forms and attached papers, if any, make up the entire contract between the **Policyholder** and **Us**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by **You** will be used in any contest unless a copy of the statement is furnished to **You** or **Your** beneficiary or personal representative.

No changes in the **Policy** will be valid until approved by an officer of **Our's**. The approval must be noted on or attached to the **Policy**. No agent may change the **Policy** or waive any of its provisions.

CERTIFICATE OF INSURANCE
We will provide the **Policyholder** with a Certificate of Insurance, in either paper or electronic format, for delivery to each **Insured Person**, where required by state law. Such Certificate of Insurance will contain a summary of terms that affect benefits.

INCONTESTABILITY
The validity of the **Policy** will not be contested after it has been in force for two year(s) from the Policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

POLICYHOLDER RECORDS
The **Policyholder** will keep a record of the coverage, premium, beneficiary designation and other pertinent administrative information for each **Insured Person** which, if acceptable to **Us**, shall be deemed to be a part of the **Policy**. **We** may examine these records at any reasonable time while the **Policy** is in force and for six (6) years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured Person**. [The **Policyholder** shall indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the administration described herein.]

PHYSICAL EXAMINATION AND AUTOPSY
We have the right, at **Our** own expense, to examine the **Insured Person** whose **Injury** is the basis of a claim, when and as often as it may be reasonably required while a claim is pending. **We** may also require an autopsy where it is not prohibited by law.

LEGAL ACTIONS
In those states where binding arbitration is not allowed, no legal action for a claim can be brought against **Us** until sixty (60) days after receipt of written Proof of Loss. In those states where binding arbitration is not allowed, no legal action for a claim can be brought against **Us** more than three (3) years (six (6) years in South Carolina and Wisconsin, five (5) years in Kansas, Florida and Tennessee) after the time for giving written Proof of Loss. In those states where binding arbitration is allowed, binding arbitration shall supersede this provision.

NONCOMPLIANCE WITH POLICY REQUIREMENTS
Any express waiver by **Us** of any requirements of the **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

CONFORMITY WITH STATE STATUTES
Any provision of the **Policy** that, on its effective date, is in conflict with the statutes of the state in which the **Policy** was delivered, is hereby amended to conform to the minimum requirements of such laws.

CLERICAL ERROR
Clerical error, whether by the **Policyholder**, the Producer or **Us**, in keeping records pertaining to the **Policy**, will not:
1. invalidate coverage otherwise validly in force; or
2. continue coverage otherwise validly terminated.

DATA REQUIRED
The **Policyholder** must maintain adequate records acceptable to **Us** and provide any information required by Us relating to this insurance.

AUDIT
We will have the right to inspect and audit, at any reasonable time, all records and procedures of the **Policyholder** that may have a bearing on this insurance.

ASSIGNMENT
The **Policy** is non-assignable.

SUBROGATION
We have the right to recover all payments including future payments, which **We** have made to **You** or on behalf of **Your** covered dependents, heirs, guardians or executors or will be obligated to pay in the future to **You**, from any **Third Party**. If **You** recover from any **Third Party**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to **You**. **You** agree to assist **Us** in preserving **Our** rights against any **Third Party**, including but not limited to, signing subrogation forms supplied by **Us**.

[**MADE WHOLE DOCTRINE**
We have the right to recover any and all first monies paid (or payable) to or on behalf of **You** and to any and all claims of or on behalf of **You**, to the extent of benefits paid by the **Policy**, and regardless of whether or not the beneficiary has been made whole. Made whole shall include first dollar recovery with no offset for attorneys' fees.]

RIGHT TO RECOVER OVERPAYMENTS
In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** shall have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to **You** (and **Your** assignee) under the **Policy** to the extent of the overpayment.

CONDITIONAL CLAIM PAYMENT
If **You** suffer a **Covered Loss** as the result of an **Injury** for which a **Third Party** may be liable, **We** will pay the amount of benefits otherwise payable under the **Policy**. However, if **You** receive payment from the **Third Party**, **You** agree to refund to **Us** the lesser of:
1. the amount actually paid by **Us** for such **Covered Loss**; or
2. an amount equal to the sum actually received from the **Third Party** for such **Covered Loss**.

If **You** do not receive payment from the **Third Party** for such **Covered Loss**, **We** reserve the right to subrogate under the Subrogation clause of the **Policy**.

At the time such **Third Party** liability is determined and satisfied, this amount shall be paid whether determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.

[**CLAIMS FOR WORKERS' COMPENSATION AND OTHER INSURANCE**
No benefits shall be payable under the **Policy** for any loss for which **You** claim or file for any workers' compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, **We** shall determine **Our** liability under the **Policy**. **We** reserve the right to recover, from **You**, any benefits paid under the **Policy** that are subsequently paid for under any workers' compensation, employers' liability, occupational disease or similar law or any other insurance.]

[Workers' Compensation Indemnification. If **You** are determined by a court of law or the appropriate state regulatory authority to be covered under workers' compensation insurance for a **Covered Loss**, any benefits for which **You** are eligible under the **Policy**, are payable to the person who was determined to be **Your** employer or such person's designee or assignee.]

SECTION XI – IMPORTANT NOTICE

You may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if You need assistance in resolving any complaints. Or, You may write to Zurich American Insurance Company at their administrative offices at [XXXXXX].

Should You wish to contact the Arkansas Insurance Department for assistance, You may do so by calling [1-800-282-9134]. Or, You may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

Enrollment and Beneficiary Designation Form

Occupational Accident Insurance

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

MOTOR CARRIER INFORMATION (Please print)			
Name of Motor Carrier:			Contact Name:
Address:			Telephone:
City:	State:	Zip:	Email Address:
Effective Date of Your Contract:			

INDIVIDUAL DRIVER INFORMATION (Please print)			
Name:		FEIN Number:	☐ None
Address:		CDL Number:	
City:	State: Zip:	Number of Years Experience:	
Date of Birth:	☐ Male ☐ Female	Height:	Weight:
Home Phone:	Cell Phone:	Email Address:	
Beneficiary:			
Relationship to Beneficiary:			

GENERAL INFORMATION

YOU ARE NOT ELIGIBLE FOR COVERAGE IF YOU ARE AN EMPLOYEE DRIVER

1. Do you own and operate your own truck? ☐ Yes ☐ No
2. Do you operate a truck under a lease to purchase plan? ☐ Yes ☐ No
3. Do you operate a truck as a 1099 contract driver, but do not own or lease the truck? ☐ Yes ☐ No
   If Yes, for whom?
4. Do you operate a truck as part of a team or as a co-driver? ☐ Yes ☐ No
   If Yes, with whom?
5. Equipment type: ☐ Box ☐ Flatbed ☐ Intermodal ☐ Tanker ☐ Refrigerated ☐ Dump ☐ Straight Truck
   ☐ Other, please specify:
6. Have you filed a workers' compensation or occupational accident claim in the past 3 years? ☐ Yes ☐ No
   If Yes, please explain:
7. Are you covered under any other medical and/or disability insurance plan? ☐ Yes ☐ No
   If Yes, name of insurance carrier:

INSURANCE FRAUD WARNING
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand and hereby acknowledge the following:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither I nor the Motor Carrier above can become participants in the Workers' Compensation system by purchasing this insurance;
2. I certify that I am actively at work at least [20] hours per week for the Motor Carrier above and meet the eligibility requirements under the Policy. I understand that if I am not eligible, no benefits will be paid and this coverage will be cancelled and premiums returned;
3. I certify that I am an independent contractor and receive a 1099 tax form. I further certify that I am not an employee and do not receive a W-2 tax form. I understand coverage will be terminated and no benefits paid if I am an employee;
4. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records to furnish such information or copies of records to Zurich American Insurance Company, the Motor Carrier or the Motor Carrier's designee. A photographic copy of this authorization shall be as valid as the original;
5. I certify to the best of my knowledge and belief that all information on this form is complete and truthful; and
6. I authorize the above named Motor Carrier with whom I have a contract, to take monthly deductions, equal to my premiums, from my settlement account on my behalf, and to remit these funds to Zurich American Insurance Company or its appointed agent. I understand that the cost of the insurance is my sole obligation and responsibility regardless of the above arrangement.

Driver's Signature: _____ Date: _____

Motor Carrier Representative: _____ Phone/Fax Number: _____

Administrative Change Endorsement

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS ENDORSEMENT CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the [Truckers] Occupational Accident Insurance Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

[This endorsement will be used to make the following types of administrative changes to the **Policy/Certificate** at the Policyholder's request:

1. Policyholder's Name or Address;
2. Addition or deletion of subsidiaries or affiliates of the Policyholder;
3. Changes to the class(es) of eligible persons;
4. Addition or deletion of Benefit(s);
5. Increase or decrease in Benefit Amount(s);
6. Addition or deletion of Additional Benefit(s);
7. Increase or decrease in Additional Benefit Amount(s); or
8. Annual audit requirements.]

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Occupational Accident Insurance Policy - Forms*		
Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/04/2009

Comments:

Attachment:

10-20-09 ZAIC [Truckers][Occupational] Accident Form Filing Certificate of Readability.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/04/2009

Comments:

Applications attached to forms schedule.

		Item Status:	Status Date:
Satisfied - Item:	Explanatory memorandum and statement of variables	Approved-Closed	11/04/2009

Comments:

Attachments:

10-20-09 U-OA Explanatory Memorandum.pdf

U-OA Statement of Variables for Arkansas.pdf

		Item Status:	Status Date:
Satisfied - Item:	Redlined copies tracking changes to forms	Approved-Closed	11/04/2009

Comments:

Attachments:

11-03-09U-OA-400-A AR - [Truckers][Occupational] Accident Policy REDLINED.pdf

11-03-09U-OA-402-A AR - [Truckers][Occupational] Accident Certificate REDLINED.pdf

Certificate of Readability

Zurich American Insurance Company

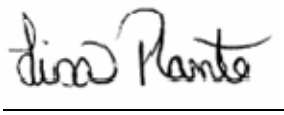
I have reviewed or supervised the preparation of the attached policy forms. I hereby certify that to the best of my knowledge, information, and belief, these policy forms comply with the minimum readability standards required by your State Insurance Code.

The policy forms listed below have achieved the following Flesch Scores using the Flesch Reading Ease software published by Micro Power & Light Co.:

Form Number	Title	Flesch Score
U-OA-400-A (08/09)	[Truckers][Occupational] Accident Insurance Policy	45
U-OA-401-A (08/09)	Group Application	50
U-OA-402-A (08/09)	[Truckers][Occupational] Accident Insurance Certificate	48
U-OA-403-A (08/09)	Enrollment and Beneficiary Designation Form	50
U-OA-404-A (08/09)	Administrative Change Endorsement	48

Although some of the forms listed above may not have achieved the minimum readability standards required by your State Insurance Code, we respectfully request approval based on our belief that:

1. the lower score provides a more accurate reflection of the readability of the form(s); and
2. the lower score is warranted by the nature of the particular form(s) or type or class of form(s).

Signature: 

Officer: Lisa Plante

Title: Vice President, Accident & Health

Date: October 16, 2009

Zurich American Insurance Company

EXPLANATORY MEMORANDUM
[Truckers][Occupational] Accident Insurance Policy
Company Filing Number – CW AH 29187
U-OA-400-A (08/09), et al

This is a new Group Occupational Accident Insurance product designed to provide accidental death and dismemberment benefits to transportation-related independent contractors for losses resulting primarily from occupational injuries. Please note, however, this Group Occupational Accident Insurance product is not a substitute for Workers' Compensation coverage.

This Group Occupational Accident Insurance product will be marketed to groups in your state consisting of two (2) or more individuals and may be marketed through brokers, consultants, third party administrators and sales employees.

All forms are new and are not intended to replace any other forms currently in use.

The forms are being filed concurrently in our domiciliary state of New York.

Variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific Policyholder's request. Variable data will never exclude or limit provisions required by the jurisdiction in which the Policy is issued.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. While every effort has been made to submit this filing without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

The Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

This filing includes a certification of readability and statement of variables.

Statement of Variables for Arkansas

Zurich American Insurance Company
Schaumburg, Illinois

[TRUCKERS][OCCUPATIONAL] ACCIDENT INSURANCE POLICY
U-OA-400-A, et al

Each bracketed benefit or provision will be in or out (in if needed, otherwise omitted.) Each bracketed phrase will be in or out.

[TRUCKERS][OCCUPATIONAL] ACCIDENT INSURANCE POLICY – U-OA-400-A AR (08/09)

Face Page

[Truckers][Occupational] Accident Insurance Policy	**[Truckers]** will be in or out. **[Occupational]** will be in or out.

Page 3

[1-888-889-5330]	This is variable in the event there is a change in the Company's telephone number.

SECTION I – SCHEDULE

Policy Effective Date: [01/01/09]	Policy Effective Date will be inserted.
[**Policy Period**: [01/01/09] to [01/01/10]]	This will be in or out. If in, the effective date and expiration date will be inserted.
Policy Premium Due Date: [01/01/09]	Policy Premium Due Date will be inserted.
Policy Number: [XXXXXX-XX]	Policy number will be inserted.
Insured Person's Premium: [$0.00]	Insured Person's Premium will be inserted.
Policyholder: [Name of Trucking Company] [Address] [City, State, Zip]	Name of the Policyholder will be inserted. Policyholder's address will be inserted. Policyholder's City, State and Zip will be inserted.

Benefits Summary

	Occupational Injuries	**Non-Occupational Injuries .**	
Accidental Death Benefit:			
Principal Sum*	[$50,000.00]	[$7,500.00]	[$50,000] The range is $5,000 - $500,000 [$7,500] The ranges is $2,500 - $500,000
Commencement Period	[365 days]	[365 days]	[365] The range is 365 – 1,095 for both
Survivor's Benefit:			
Principal Sum*	[$175,000.00]	[$7,500.00]	[$175,000] The range is $5,000 - $500,000 [$7,500] The range is $2,500 - $500,000
Monthly Benefit Percentage of **Principal Sum**	[1.0%]	[1.0%]	[1.0%] The range is 1% - 10% for both
Monthly Benefit Amount	[$1,750.00]	[$1,750.00]	[$1,750] The range is $50 - $50,000 [$1,750] The range is $25 - $50,000

	Occupational Injuries	**Non-Occupational Injuries .**	
Accidental Dismemberment Benefit:			
Principal Sum*	[$225,000.00]	[$7,500.00]	[$225,000] The range is $5,000 - $500,000 {$7,500] The range is $2,500 - $500,000
Commencement Period	[365 days]	[365 days]	[365] The range is 365 – 1,095 for both
Accidental Paralysis Benefit:			
Principal Sum*	[$225,000.00]	[$7,500.00]	[$225,000] The range is $5,000 - $500,000 [$7,500] The range is $2,500 - $500,000
Commencement Period	[365 days]	[365 days]	[365] The range is 365 – 1,095 for both
Accident Medical Expense Benefit:			
Commencement Period	[90 days]	[90 days]	[90] The range is 90 – 365 for both
Deductible Amount	[$0.00]	[$0.00]	[$0.00] The range is $0 - $5,000 for both
Maximum Benefit Amount	[$1,000,000.00]	[$5,000.00]	[$1,000,000] The range is $150,000-$5,000,000 [$5,000] The range is $2,500 - $1,000,000
Maximum Benefit Period	[104 weeks]	[52 weeks]	[104] The range is 52 – 260 [52] The range is 52 – 260
Dental Benefit Maximum	[$2,500.00]	[$1,000.00]	[$2,500] The range is $1,000 - $20,000 [$1,000] The range is $1,000 - $20,000
Lifetime **Maximum Benefit Amount**	[$1,000,000.00]	[$10,000.00]	[$1,000,000] The range is $150,000-$5,000,000 [$10,000] The range is $2,500 - $500,000
Physical, Occupational, or Work Hardening Therapies	To a maximum combined [36] visits	[N/A]	[36] The range is 0 – 100 [N/A] The range is either N/A or the same as for Occupational Injuries
Ambulance for Medically Necessary Services	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**	[1] The range is 1 – 5 for both [$10,000] The range is $1,000-$25,000 for both
Acupuncture Care and Chiropractic Care	[$1,000.00] per **Injury**	N/A	[$1,000] The range is $1,000 - $25,000
[Hernia Coverage]	[$10,000.00]	N/A	[Hernia Coverage] will be in or out. If in: [$10,000] The range is $1,000 - $25,000
[Hemorrhoid Coverage]	[$10,000.00]	N/A	[Hemorrhoid Coverage] will be in or out. If in: [$10,000] The range is $1,000 - $25,000
Mental and Nervous or Depressive Condition	1 visit per day to a maximum of [$25.00] per visit and [20] visits per **Accident**	N/A	[$25] The range is $25 - $100 [20] The range is 10 - 100

	Occupational Injuries	Non-Occupational Injuries	
[**Occupational Cumulative Trauma**]	[$20,000.00]	N/A	[**Occupational Cumulative Trauma**] will be in or out. If in: [$20,000] The range is $10,000 - $1,000,000
[**Occupational Disease**]	[$20,000.00]	N/A	[**Occupational Disease**] will be in or out. If in: [$20,000] The range is $10,000 - $1,000,000
Temporary Total Disability Benefit:			
Commencement Period	[90 days]	[90 days]	[90 days] The range is 90 – 365 for both
Waiting Period	[7 days]	[7 days]	[7 days] The range is 0 – 30 for both
Benefit Percentage	[70.0%]	[70.0%]	[70.0%] The range is 60% - 80% for both
Minimum Weekly Benefit Amount	[$125.00]	[$125.00]	[$125] The range is $125 - $250 [$125] The range is $50 - $250
Maximum Weekly Benefit Amount	[$500.00]	[$500.00]	[$500] The range is $250 - $1,000 [$500] The range is $50 - $1,000
Maximum Benefit Period**	[104 weeks]	[12 weeks]	[104 weeks] The range is 52 – 260 [12 weeks] The range is 0 – 104
[**Maximum Benefit Period** for Hernia]	[90 days]	N/A	[90 days] The range is 30 – 365
[**Maximum Benefit Period** for Hemorrhoid]	[90 days]	N/A	[90 days] The range is 30 – 365
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**]	[90 days]	N/A	[90 days] The range is 90 - 365
[**Maximum Benefit Period** for **Occupational Disease**]	[90 days]	N/A	[90 days] The range is 90 - 365
Continuous Total Disability Benefit: ***			
Waiting Period	[equals **Maximum Benefit Period** for **Temporary Total Disability**]	N/A	[equals **Maximum Benefit Period** for **Temporary Total Disability**] will be in or out.
Benefit Percentage	[70.0%]	N/A	[70.0%] The range is 60% - 80%
Minimum Weekly Benefit Amount	[$50.00]	N/A	[$50] The range is $50 - $250
Maximum Weekly Benefit Amount	[$500.00]	N/A	[$500] The range is $250 - $1,000
Maximum Benefit Amount	[$300,000.00]	N/A	[$300,000] The range is $200,000 - $1,000,000
Maximum Benefit Period	Up to age 70, but not beyond full Social Security retirement age	N/A	

	Occupational Injuries	Non-Occupational Injuries	
Additional Benefits:			
[Return of Remains Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Non-Medical Repatriation Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[After School Care Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Coma Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Critical Burn Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Day Care Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Felonious Assault Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Higher Education Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Hijacking Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Vehicle Modification Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Seat Belt Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Spouse Retraining Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
Limits of Liability:			
Combined Single Limit of Liability	[$1,000,000.00]	[$10,000.00]	[$1,000,000] The range is $500,000-$5,000,000 [$10,000] The range is $2,500 - $1,000,000
Aggregate Limit of Liability	[$2,000,000.00]	[$15,000.00]	[$2,000,000] The range is $500,000-$5,000,000 [$15,000] The range is $2,500 - $1,000,000
Sub Limits of Liability:			
[**Combined Single Limit of Liability** for:			
[Hernia]	[$20,000.00]	N/A	[$20,000] The range is $1,000 - $25,000
[Hemorrhoid]	[$20,000.00]	N/A	[$20,000] The range is $1,000 - $25,000
[**Occupational Disease**]	[$50,000.00]	N/A	[$50,000] The range is $10,000 - $1,000,000
[**Occupational Cumulative Trauma**]	[$50,000.00]	N/A	[$50,000] The range is $10,000 - $1,000,000

* Starting at age [65], the **Principal Sum** shall be based on the following schedule: Age at Date of Loss — Percent of **Principal Sum** [65] — [80%] [66] — [60%] [67] — [40%] [68] — [20%] [69] — [15%] [70 and over] — [10%]	[65] The range is 65 - 70 [65] The range is 65 – 70 [80%] The range is 80% - 100% [66] The range is 66 – 71 [60%] The range is 60% - 100% [67] The range is 67 – 72 [40%] The range is 40% - 100% [68] The range is 68 – 73 [20%] The range is 20% - 100% [69] The range is 69 – 74 [15%] The range is 15% - 100% [70 and over] The range is 75 and over [10%] The range is 10% - 100%
** If an **Insured Person** suffers an **Injury** at or after age [70], the **Maximum Benefit Period** shall be [one (1) year].	[70] The range is 70 – 75 [one (1) year] The range is 1 - 3

SECTION II – GENERAL DEFINITIONS

Actively at Work means under **Dispatch** for at least [30] hours each week.	[30] The range is 15 - 30
Contract Driver means an individual who: 1. [has a valid and current commercial driver's license on the effective date of enrollment;] 2. [is authorized by an **Owner/Operator** to operate a power unit owned or leased by an **Owner/Operator** and must neither own nor lease the power unit;] 3. [is compensated on a basis other than time expended in the performance of work;] 4. [is responsible for determining the route and time for **Assignment**;] 5. [has the principal duty to operate the power unit;] 6. [is classified as an independent contractor by the **Policyholder** and the **Owner/Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance, or for any other purpose, [unless workers' compensation coverage is not mandatory for such person as an employee of either the **Policyholder** or **Owner/Operator**];] and 7. [receives for federal income tax reporting purposes a 1099 and not a W-2].	Any combination of 1. – 7. will be in or out.
Dependent Child(ren) means the **Insured Person's** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption, who are: 1. under age 19 or under age 23 if he or she [:] [(a)] is enrolled in accredited institution of higher learning on a full-time basis, [and (b) relies on the **Insured Person** for more than 50% of his or her	(a) will be in or out (b) will be in or out

support and is taken as a dependent on the Federal Income Tax Return of the **Insured Person**]; or 2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the **Insured Person** for support and maintenance as defined herein.	
Dispatch means the time during which an **Insured Person** is on **Assignment** or is performing tasks prior to or after an **Assignment** to prepare the contracted vehicle for a current or future **Assignment**. **Dispatch** must be authorized by the **Policyholder** and includes the following: 1. in route to pick up a load; 2. picking up a load; 3. in route to delivering a load; 4. unloading a load; 5. the waiting time for a load; 6. returning from delivering a load; 7. in route to, returning from or performing a pre-trip inspection as required by a recognized governmental agency and/or the contracted motor carrier; 8. [while performing vehicle maintenance or repairs on the contracted vehicle during any of the foregoing times; and] 9. [while performing verifiable vehicle maintenance or repairs on the contracted vehicle; and] 10. performing activities to comply with federal or state laws or to satisfy contracted motor carrier requirements.	8. will be in or out. 9. will be in or out.
Owner/Operator means an individual who leases to or from the **Policyholder** and: 1. [has a valid and current commercial driver's license on the effective date of enrollment;] 2. [owns or leases a power unit;] 3. [is responsible for the maintenance and operating costs of the power unit, including, but not limited to fuel, repairs and supplies;] 4. [is compensated on a basis other than time expended in the performance of work;] 5. [is responsible for determining the route and time for **Assignment**;] 6. [has the right to select or reject the load;] 7. [has a written contract or **Assignment** from the **Policyholder** and is classified as an independent contractor by the **Policyholder** and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;] and 8. [receives for federal income tax reporting purposes a 1099 not a W-2].	Any combination of 1. – 8. will be in or out.
Policy means this [Truckers][Occupational] Accident Insurance Policy.	[Truckers] will be in or out. [Occupational] will be in or out.
Waiting Period means the consecutive number of days an **Insured Person** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Policy**. **Temporary Total Disability Benefits** and **Continuous Total Disability Benefits** are[not] retroactive to the first day of disability. The **Waiting Period** is shown in the **Schedule**.	[not] will be in or out.

SECTION III – EFFECTIVE DATES AND TERMINATION DATES

Policy Effective and Termination Dates	

2. Policy Termination Date. This **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of: a. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**; b. the date specified in the written notice of the **Company's** intent to terminate this **Policy**, which will be at least [thirty (30)] days after the date the **Company** sends such notice to the **Policyholder's** last known recorded address; c. the date specified in the written notice of the **Policyholder's** intent to terminate this **Policy**, which will be at least [thirty (30)] days after the date the **Policyholder** sends such notice to the **Company**; or d. at the expiration of the **Policy Period**.	[thirty (30)] The range is 30 – 90 [thirty (30)] The range is 30 - 90

SECTION IV - PREMIUMS

PREMIUMS Premiums are payable to the **Company** in the amount shown in the **Schedule**. The **Company** may change the required premiums due by giving the **Policyholder** at least [sixty (60) days] advance written notice. The **Company** may change the required premiums as a condition of any renewal of this **Policy**. The **Company** may also change the required premiums at any time when any change affecting premiums is made in this **Policy**. The **Company** may re-underwrite and may change the terms and conditions of this **Policy** including the premium rate on the date when the number of **Insured Persons** under this **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [fifteen percent (15%)] or more. The **Policyholder** shall provide the **Company** with written notice of such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.	[sixty (60) days] The range is 30 - 90 [fifteen percent (15%)] The range is 15% - 100% [thirty (30) days] The range is 30 - 90
PLAN AND EXPOSURE CHANGES The **Policyholder** must notify the **Company** of any subsidiary or affiliated company that is to be covered under this **Policy**. Such notice must be sent within [thirty (30) days] of the acquisition of such subsidiary or affiliated company. If such notice is not provided, the newly acquired entity will not be considered a part of the **Policyholder** and the owner/operators or contract drivers will not be **Insured Persons** until the date that notice is provided. The **Company** has the right to decline coverage or adjust premium based on the changing exposure.	[thirty (30) days] The range is 30 - 90
INSURED PERSON'S GRACE PERIOD A grace period of [thirty-one (31) days] will be provided for the payment of any **Insured Person's** Premium due after the first premium. The **Insured Person's** coverage will not be terminated for non-payment of premium during this grace period if the **Insured Person** pays the premium due by the last day of this grace period. The **Insured Person's** coverage will terminate if the full amount of the premium due is not paid by the last day of this grace period.	[thirty-one (31) days] The range is 31 - 90
POLICY GRACE PERIOD A grace period of [thirty-one (31)] days will be provided for the payment of any premium due after the first premium. This **Policy** will not be terminated for nonpayment of premium during this grace period	[thirty-one (31) days] The range is 31 - 90

if the **Policyholder** pays all premiums due by the last day of this grace period. This **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of this grace period. No Policy Grace Period will be provided if the **Company** receives notice to terminate this **Policy** prior to a premium due date.	

SECTION V - BENEFITS

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to the **Insured Person** results in any one of the **Losses** specified below within the **Commencement Period**, the **Company** will pay the Percentage of the **Principal Sum** shown below:

For **Loss** of:	Percentage of the **Principal Sum**	
Both Hands or Both Feet	[100%]	[100%] The range is 50% - 100%
Sight of Both Eyes	[100%]	[100%] The range is 50% - 100%
One Hand and One Foot	[100%]	[100%] The range is 50% - 100%
One Hand and the Sight of One Eye	[100%]	[100%] The range is 50% - 100%
One Foot and the Sight of One Eye	[100%]	[100%] The range is 50% - 100%
One Hand or One Foot	[50%]	[50%] The range is 50% - 100%
Sight of One Eye	[50%]	[50%] The range is 50% - 100%
Thumb and Index Finger of Same Hand	[25%]	[25%] The range is 25% - 100%
Speech and Hearing	[50%]	[50%] The range is 25% - 100%
Speech or Hearing	[25%]	[25%] The range is 25% - 100%

PARALYSIS BENEFIT

If **Injury** to the **Insured Person** results in any Type of Paralysis specified below within the **Commencement Period**, the **Company** will pay the Percentage of the **Principal Sum** shown below:

Type of Paralysis:	Percentage of the **Principal Sum**	
Quadriplegia	[100%]	[100%] The range is 50% - 100%
Paraplegia	[75%]	[75%] The range is 25% - 100%
Hemiplegia	[50%]	[50%] The range is 25% - 100%
Uniplegia	[25%]	[25%] The range is 25% - 100%

TEMPORARY TOTAL DISABILITY BENEFIT

If **Injury** to the **Insured Person** results in **Temporary Total Disability** within the **Commencement Period** and the **Insured Person** is under age [70] on the day the **Temporary Total Disability** begins, the **Company** will pay the following amount, after the **Waiting Period**:

For this benefit, the following definitions apply:

Average Weekly Earnings means:

1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income the **Insured Person** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who are contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or

This will be in or out. If in:
[Thirty-three percent (33%)] The range is 25% - 75%

[Thirty-three percent (33%)] The range is 25% - 75%

[Thirty-three percent (33%)] The range is 25% - 75%

unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation.]	[Thirty-three percent (33%)] The range is 25% - 75%
2. [for **Contract Drivers**: [Seventy-five percent (75%)] of the gross income the **Insured Person** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [seventy-five percent (75%)] of the average gross income received by other **Insured Persons** who are contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation provided he/she was not an **Owner/Operator**. If he/she was an **Owner/Operator**, then we will use 33% of the gross income.]	This will be in or out. If in: [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75%
Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the **Maximum Weekly Benefit Amount**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.	[seventy percent (70%)] The range is 60% - 80%
Temporary Total Disability or Temporarily Totally Disabled means disability that: 1. prevents an **Insured Person** from performing the **Material and Substantial Duties** of his or her occupation [as a commercial truck driver];	[as a commercial truck driver] will be in or out.
CONTINUOUS TOTAL DISABILITY BENEFIT If **Injury** to the **Insured Person** resulting in **Temporary Total Disability** subsequently results in **Continuous Total Disability**, the **Company** will pay the following, after the **Waiting Period**: 1. for each month of a **Continuous Total Disability**, the Continuous Total Disability Benefit is four and three-tenths (4.3) times the **Weekly Benefit Amount** for **Temporary Total Disability**; or 2. for less than a full **Benefit Week** of **Continuous Total Disability**, the Continuous Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Continuous Total Disability**, but only if: a. Temporary Total Disability Benefits ceased solely because the **Maximum Benefit Period** has been reached, but the **Insured Person** remains disabled; b. the **Insured Person** is not within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration, on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached; c. the **Insured Person** has been granted a Social Security	

disability award for his or her disability (if the **Insured Person** cannot meet the credit requirement for a Social Security disability award he or she cannot qualify for the Continuous Total Disability Benefit even if he or she would otherwise qualify); d. the **Insured Person's** disability is reasonably expected to continue without interruption until he or she dies and is substantiated by objective medical evidence satisfactory to the **Company**; e. the **Injury** resulting in a **Continuous Total Disability** occurred before the **Insured Person** is within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration; [and] f. the **Injury** began within the **Commencement Period** [.] [; and] g. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**.]	g. will be in or out
For this benefit, the following definitions apply: **Average Weekly Earnings** will be calculated as follows: 1. [for **Owner/Operators**: [Thirty-three percent (33%)] of the gross income the **Insured Person** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who are contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation.]	This will be in or out. If in: [Thirty-three percent (33%)] The range is 25% - 75% [Thirty-three percent (33%)] The range is 25% - 75% [Thirty-three percent (33%)] The range is 25% - 75% [Thirty-three percent (33%)] The range is 25% - 75%
2. [for **Contract Drivers**: [Seventy-five percent (75%)] of the gross income the **Insured Person** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [seventy-five percent (75%)] of the average gross income received by the other **Insured Persons**, who are contracted within the last three (3) months prior to the covered **Injury**. If the **Insured Person** and/or **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation provided he/she was not an	This will be in or out. If in: [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75%

Owner/Operator. If he/she was an **Owner/Operator**, then we will use 33% of the gross income.]	
Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the Maximum Weekly Benefit. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.	[seventy percent (70%)] The range is 60% - 80%
ACCIDENT MEDICAL EXPENSE BENEFIT	
Home Health Care means nursing care and treatment of an **Insured Person** in his or her home as part of a treatment plan prescribed by the attending **Physician**, which is provided by a **Hospital** or agency certified to provide such services, but only if it:	
1. begins within [seven (7)] days after discharge from a **Hospital**; and	[seven (7)] The range is 1 - 30
2. follows a **Hospital** confinement of [five (5)] days or more.	[five (5)] The range is 1 – 30
Usual and Customary Charge(s) means an amount(s) that:	
1. does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and	
2. does not include charges that would not have been made if no insurance existed[; and	
3. does not exceed the cost of a generic drug, if available. The **Company** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available].	[seventy-five percent (75%)] The range is 25% - 100%
ACCIDENT MEDICAL EXPENSE BENEFIT EXCLUSIONS In addition to the General Exclusions and Limitations in Section VIII of this **Policy**, **Medically Necessary Services or Charges** do not include expenses for or resulting from any of the following:	
9. any expenses covered by [Medicare, Medicaid,] a **Third Party** [or any other insurance];	[Medicare, Medicaid,] will be in or out [or any other insurance] will be in or out
13. an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;	[five (5)] The range is 1 - 10

SECTION VI - ADDITIONAL BENEFITS

[**RETURN OF REMAINS BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay for the transport of the body or remains (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to the **Insured Person's** county of residence. We must be contacted prior to the transportation of the body or remains and we must pre-authorize the transportation for coverage to apply. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]	This Additional Benefit will be in or out. If in: [one thousand dollars ($1,000)] The range is $250 - $2,500
[**NON-MEDICAL REPATRIATION BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accident Medical Expense Benefit and has sufficiently recovered to travel in a regularly scheduled economy class air flight, commercial bus or train and without special medical equipment or personnel with a minimal risk to his or her health, the	This Additional Benefit will be in or out. If in:

Company will pay for the return to his or her principal residence. We must be contacted prior to the transport and we must agree to the travel itinerary for coverage to apply. This benefit is subject to the prior recommendation of the attending **Physician**. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]	[one thousand dollars ($1,000)] The range is $250 - $2,500
[**AFTER SCHOOL CARE BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit for after school care to the individual who incurs the expense on behalf of each **Dependent Child** who is [ten (10)] years old or less, up to a maximum of the lesser of: 1. [two percent (2%)] of the applicable **Principal Sum** paid under the Accidental Death Benefit per year; or 2. [two thousand dollars ($2,000)] per year. The after school care provider may not be an **Immediate Family Member** and written proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, to establish continued eligibility for this benefit. This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child** is under age [ten (10)] at the time of each payment. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]	This Additional Benefit will be in or out. If in: [ten (10)] The range is 3 - 16 [two percent (2%)] The range will be 1% - 3% [two thousand dollars ($2,000)] The range will be $1,500 - $5,000 [four (4)] The range will be 1 - 8 [ten (10)] The range will be 3 - 16 This will be in or out. If in: [eight thousand dollars ($8,000)] The range is $4,000 - $12,000
[**COMA BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** and within three hundred sixty-five (365) days of the **Accident** which caused such **Injury**, such **Injury** causes the **Insured Person** to be in a **Coma** for at least thirty-one (31) consecutive days, the **Company** will pay an additional benefit equal to [one percent (1%)] of the **Principal Sum** for such **Injury**, and such amount will be paid each month the **Insured Person** remains in a **Coma** following the initial thirty-one (31) day period. At the end of eleven (11) months of payment, if the **Insured Person** remains in a **Coma**, the **Company** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the eleven (11) months of benefit already received. The Coma Benefit will end on the earliest of the following: 1. the date the **Insured Person** is no longer in the **Coma**; or 2. the date the **Insured Person** has received a Coma Benefit for eleven (11) months. The **Company** may require receipt of written proof, at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit. For this benefit, the following definition applies: **Coma** means a condition determined as such by the **Company's** duly licensed **Physician**.]	This Additional Benefit will be in or out. If in: [one percent (1%)] The range is 1% - 5%
[**CRITICAL BURN BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss**, the **Company** will pay an additional benefit equal to the lesser of [ten	This Additional Benefit will be in or out. If in: [ten percent (10%)] The range is 5% - 25%

percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)], but only if the **Insured Person**: 1. suffered second degree or higher burns over [twenty-five percent (25%)] of his or her body; and 2. has undergone reconstructive surgery to treat the burned areas of the body within three hundred sixty-five (365) days of the occurrence of the **Accident** that caused the **Injury**.]	[ten thousand dollars ($10,000)] The range is $5,000 - $30,000 [twenty-five percent (25%)] The range is 10% - 50%
[**DAY CARE BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit for day care expenses to the individual who incurs the expense for each **Dependent Child** if: 1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and 2. the **Dependent Child** is under age [thirteen (13)]. The Day Care Benefit will be equal to the lesser of: 1. the actual cost of the day care; 2. [three percent (3)%] of the **Principal Sum**; or 3. [three thousand dollars ($3,000)]; and will be paid annually for [four (4)] consecutive years if: 1. the **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and 2. written proof acceptable to the **Company** is received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit. For this benefit, the following definition applies: **Accredited Child Care Facility** means a properly licensed childcare facility that operates pursuant to state and local laws and has a Tax Identification Number issued by the Internal Revenue Service. **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]	This Additional Benefit will be in or out. If in: [ninety (90)] The range is 30 - 180 [thirteen (13)] The range is 1 - 16 [three percent (3)%] The range is 1% - 5% [three thousand dollars ($3,000)] The range is $1,000 - $6,000 [four (4)] The range is 1 - 8 [thirteen (13)] The range is 1 - 16 This will be in or out. If in: [eight thousand dollars ($8,000)] The range is $1,000 - $20,000
[**FELONIOUS ASSAULT BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** for an **Occupational Injury** payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Paralysis Benefit as a result of a **Felonious Assault** by someone other than himself or herself, an **Insured Person** or an **Immediate Family Member** or **Household Member**, the **Company** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum**, but only if: 1. the **Felonious Assault** occurs while the **Insured Person** is under **Dispatch**; and 2. the crime directly involves the **Policyholder's** or the **Insured Person's** funds or assets. For this benefit, the following definition applies:	This Additional Benefit will be in or out. If in: [ten percent (10%)] The range is 5% - 25%

Felonious Assault means the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]	
[**HIGHER EDUCATION BENEFIT** If the **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay a benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**, but only if on the date of the **Accident**, the **Dependent Child**: 1. is enrolled as a full-time student in an accredited college, university or trade school; or 2. is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**. The Higher Education Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit. [The maximum amount payable under this benefit for all **Dependent Child(ren)** combined is [twenty thousand dollars ($20,000)].]]	This Additional Benefit will be in or out. If in: [five percent (5%)] The range is 3% - 10% [five thousand dollars ($5,000)] The range is $2,500 - $10,000 [four (4)] The range is 1 - 6 This will be in or out. If in: [twenty thousand dollars ($20,000)] The range is $10,000 - $30,000
[**HIJACKING BENEFIT** The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions and Limitations of this **Policy** is modified and an **Injury** directly resulting from a **Hijacking** or any attempt at any **Hijacking** is covered under this **Policy**. This benefit will continue beyond the actual **Hijacking** while the **Insured Person** is: 1. subject to the control of the person(s) making the **Hijacking**; and 2. traveling directly to the **Insured Person's** home or original destination. For this benefit, the following definition applies: **Hijacking** means the unlawful seizure or wrongful exercise of control of a power unit occupied by the **Insured Person**, while the **Insured Person** is getting into, riding in, or getting out of and while under **Dispatch**.]	This Additional Benefit will be in or out.
[**VEHICLE MODIFICATION BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Dismemberment Benefit or Paralysis Benefit, the **Company** will pay an additional benefit equal to the actual cost for modifications to his or her motor vehicle that are necessary to make it accessible or drivable, but only if such **Injury** requires the **Insured Person** to use a wheelchair. Benefits are not payable unless: 1. the modifications are made by a person(s) experienced in such modifications and are recommended by an organization recognized for providing support and assistance to wheelchair users; and 2. proof sufficient to the **Company** is received by the **Company**, establishing eligibility for this benefit.	This Additional Benefit will be in or out. If in:

The maximum amount payable under this benefit will be the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)].]	[ten percent (10%)] The range is 3% - 10% [ten thousand dollars ($10,000)] The range is $3,000 - $25,000
[**SEAT BELT BENEFIT** If an **Insured Person** suffers an **Injury** directly resulting from an automobile **Accident** resulting in a **Covered Loss** payable under the Accidental Death Benefit or Survivor's Benefit, the **Company** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum** up to a maximum of [ten thousand dollars ($10,000)], but only if the **Insured Person** was: 1. operating or riding as a passenger in a motorized vehicle designed for use primarily on public roads; and 2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Accident**. The **Insured Person's** actual use of the seat belt or lap and shoulder restraints must be verified in the official law enforcement report of the **Accident**, through certification by the investigating officers; or by other reasonable proof, acceptable to the **Company**.]	This Additional Benefit will be in or out. If in: [ten percent (10%)] The range is 5% - 25% [ten thousand dollars ($10,000)] The range is $5,000 - $25,000
[**SPOUSE RETRAINING BENEFIT** If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit to his or her **Spouse** for the actual cost of any state licensed professional or trade-training program in which the **Spouse** enrolls and completes, but only if the purpose of the program is to obtain an independent source of support and maintenance and the actual cost is incurred within [thirty (30)] months from the death of the **Insured Person**. The Spouse Retraining Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Spouse** continues his or her training. Before this benefit is paid each year, proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit. [The maximum amount payable under this benefit is [twenty thousand dollars ($20,000)].]	This Additional Benefit will be in or out. If in: [thirty (30)] The range is 1 - 180 [five percent (5%)] The range is 3% - 10% [five thousand dollars ($5,000)] The range is $2,500 - $20,000 [four (4)] The range is 1 - 6 This will be in or out. If in: [twenty thousand dollars ($20,000)] The range is $2,500 - $30,000

SECTION VII - LIMITS OF LIABILITY

Limitation on Multiple Benefits. If an **Insured Person** can recover benefits under two or more of the Accidental Death Benefit, Accidental Dismemberment Benefit, [Coma Benefit] or the Accidental Paralysis Benefit as a result of the same **Accident**, the **Company** will pay only up to the highest applicable **Principal Sum**.	[Coma Benefit] will be in or out

SECTION VIII - GENERAL EXCLUSIONS AND LIMITATIONS

This **Policy** does not cover any losses contributed to or caused by, in whole or in part, by any of the following: 1. [suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** or any **Injury**	Any combination of 1. – 16. may be in or out.

resulting from a provoked attack;] 2. [sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning [or routine and temporary non chronic sickness or illness such as a cold, cough, headache or nausea];] 3. [a **Pre-existing Condition**, until the **Insured Person** has been continuously covered under this **Policy** for [twelve (12)] consecutive months;] 4. [**Occupational Cumulative Trauma** or **Cumulative Trauma and Repetitive Conditions**, unless shown in the **Schedule**;] 5. [**Occupational Disease**, unless shown in the **Schedule**;] 6. [performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;] 7. [declared or undeclared war, or any act of declared or undeclared war;] 8. [full-time active duty in the armed forces of any country or international authority;] 9. [any **Injury** for which the **Insured Person** is entitled to benefits pursuant to any workers' compensation law or other similar legislation;] 10. [any loss insured by employers' liability insurance;] 11. [the **Insured Person** being intoxicated: a. the **Insured Person** is conclusively deemed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the **Injury** occurs; and b. an autopsy report from a licensed medical examiner, law enforcement officer reports or similar items will be considered proof of the **Insured Person's** intoxication;] 12. [the **Insured Person** being under the influence of any illegal substance, drug, narcotic, or hallucinogen, unless such drug, narcotic, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage;] 13. [the **Insured Person's** commission of or attempt to commit a felony or a Class A misdemeanor;] 14. [travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the **Insured Person** is: a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or the **Insured Person**;] 15. [skydiving, parasailing, hang-gliding, bungee-jumping [or any similar activity];] [or] 16. [charges incurred for treatment of a covered **Injury**, when the **Insured Person** obtains compensation for the covered **Injury** from a **Third Party**].	If in: [twelve (12)] The range is 6 - 24
[INCARCERATION LIMITATION Benefits provided to an **Insured Person** will cease while the **Insured Person** is incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when the **Insured Person** is released from such facility.]	This will be in or out.

SECTION IX - CLAIM PROVISIONS

NOTICE OF CLAIM Written notice of claim must be received by the **Company** within twenty (20) days after an **Insured Person's** loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the **Company** at Zurich American Insurance Company Group Accident Claims Division, [P.O. Box 968041 Schaumburg, IL 60196] with information sufficient to identify the **Insured Person**, is deemed notice to the **Company**.	The Company's mailing address is variable in the event it changes.
SUNSET In no event shall benefits under this **Policy** be payable unless written Proof of Loss is received by the **Company** within [three (3) years] from the date of the **Accident**.	[three (3) years] The range is 3 - 10
[**ARBITRATION** Any contest to a claim denial under this **Policy** shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration shall occur at the offices of the American Arbitration Association nearest to the **Insured Person** or the person claiming to be the beneficiary. The arbitrator(s) shall not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Insured Person** or the person claiming to be the beneficiary is a citizen of a state where the law does not allow binding arbitration in an insurance policy but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. [Non-binding arbitration is required and no legal action may be brought by the **Insured Person**, the beneficiary, or the **Company** until thirty (30) days after the arbitrator(s) issues a non-binding award.] This provision bars the institution of any individual or class action lawsuit brought by the **Insured Person** or the beneficiary.]	This provision will be in or out. If in: This will be in or out.

SECTION X - GENERAL PROVISIONS

POLICYHOLDER RECORDS The **Policyholder** will keep a record of the coverage, premium, beneficiary designation and other pertinent administrative information for each **Insured Person** which, if acceptable to the **Company**, shall be deemed to be a part of this **Policy**. The **Company** may examine these records at any reasonable time while the **Policy** is in force and for six (6) years after the termination of this **Policy**. The **Policyholder** will report to the **Company** within a reasonable time all changes in information regarding an **Insured Person**. [The **Policyholder** shall indemnify the **Company** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the administration described herein.]	This will be in or out.
[**MADE WHOLE DOCTRINE** The **Company** has the right to recover any and all first monies paid (or payable) to or on behalf of the **Insured Person** and to any and all claims of or on behalf of the **Insured Person**, to the extent of benefits paid by this **Policy**, and regardless of whether or not the beneficiary has been made whole. Made whole shall include first dollar recovery with no offset for attorneys' fees.]	This provision will be in or out.
[**OFFSET DEBT** The **Company** will have, and may exercise at any time, the right to	This provision will be in or out.

offset any balance or balances, whether on account of premiums or otherwise, due from the **Policyholder** to the **Company** against any balance or balances, whether on account of losses or otherwise, due from the **Company** to the **Policyholder**.]	
[**CLAIMS FOR WORKERS' COMPENSATION AND OTHER INSURANCE** No benefits shall be payable under this **Policy** for any loss for which the **Insured Person** claims or files for any workers' compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, the **Company** shall determine its liability under this **Policy**. The **Company** reserves the right to recover, from the **Insured Person**, any benefits paid under this **Policy** that are subsequently paid for under any workers' compensation, employers' liability, occupational disease or similar law or any other insurance.]	This provision will be in or out.
[Workers' Compensation Indemnification. If an **Insured Person** is determined by a court of law or the appropriate state regulatory authority to be covered under workers' compensation insurance for a **Covered Loss**, any benefits for which the **Insured Person** is eligible under this **Policy**, are payable to the person who was determined to be the **Insured Person's** employer or such person's designee or assignee.]	This provision will be in or out.

SECTION XI – IMPORTANT NOTICE

The Insured Person may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if they need assistance in resolving any complaints. Or, the Insured Person may write to Zurich American Insurance Company at their administrative offices at [XXXXXX].	The appropriate telephone number will be inserted. The appropriate mailing address will be inserted.
Should the Insured Person wish to contact the Arkansas Insurance Department for assistance, they may do so by calling [1-800-282-9134]. Or, the Insured Person may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].	This is variable in the event of a change. This is variable in the event of a change.

[TRUCKERS][OCCUPATIONAL] ACCIDENT INSURANCE CERTIFICATE – U-OA-402-A AR (08/09)

Face Page

[Truckers][Occupational] Accident Insurance Policy **[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]**	**[Truckers]** will be in or out. **[Occupational]** will be in or out. This will be in or out.

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[1-888-889-5330]	This is variable in the event there is a change in the Company's telephone number.

SECTION I – SCHEDULE

Policy Effective Date: [01/01/09]	Policy Effective Date will be inserted.
[**Policy Period**: [01/01/09] to [01/01/10]]	This will be in or out. If in, the effective date and expiration date will be inserted.
[Policy] Premium Due Date: [01/01/09]	[Policy] will be in or out. Premium Due Date will be inserted.
Policy Number: [XXXXXX-XX]	Policy number will be inserted.
Your Premium: [$0.00]	Premium will be inserted.
Policyholder: [Name of Trucking Company] [Address] [City, State, Zip]	Name of the Policyholder will be inserted. Policyholder's address will be inserted. Policyholder's City, State and Zip will be inserted.

Benefits Summary

	Occupational Injuries	**Non-Occupational Injuries .**	
Accidental Death Benefit:			
Principal Sum*	[$50,000.00]	[$7,500.00]	[$50,000] The range is $5,000 - $500,000 [$7,500] The ranges is $2,500 - $500,000
Commencement Period	[365 days]	[365 days]	[365] The range is 365 – 1,095 for both
Survivor's Benefit:			
Principal Sum*	[$175,000.00]	[$7,500.00]	[$175,000] The range is $5,000 - $500,000 [$7,500] The range is $2,500 - $500,000
Monthly Benefit Percentage of **Principal Sum**	[1.0%]	[1.0%]	[1.0%] The range is 1% - 10% for both
Monthly Benefit Amount	[$1,750.00]	[$1,750.00]	[$1,750] The range is $50 - $50,000 [$1,750] The range is $25 - $50,000

	Occupational Injuries	**Non-Occupational Injuries .**	
Accidental Dismemberment Benefit:			
Principal Sum*	[$225,000.00]	[$7,500.00]	[$225,000] The range is $5,000 - $500,000 {$7,500] The range is $2,500 - $500,000

Commencement Period	[365 days]	[365 days]	[365] The range is 365 – 1,095 for both
Accidental Paralysis Benefit:			
Principal Sum*	[$225,000.00]	[$7,500.00]	[$225,000] The range is $5,000 - $500,000 [$7,500] The range is $2,500 - $500,000
Commencement Period	[365 days]	[365 days]	[365] The range is 365 – 1,095 for both
Accident Medical Expense Benefit:			
Commencement Period	[90 days]	[90 days]	[90] The range is 90 – 365 for both
Deductible Amount	[$0.00]	[$0.00]	[$0.00] The range is $0 - $5,000 for both
Maximum Benefit Amount	[$1,000,000.00]	[$5,000.00]	[$1,000,000] The range is $150,000-$5,000,000 [$5,000] The range is $2,500 - $1,000,000
Maximum Benefit Period	[104 weeks]	[52 weeks]	[104] The range is 52 – 260 [52] The range is 52 – 260
Dental Benefit Maximum	[$2,500.00]	[$1,000.00]	[$2,500] The range is $1,000 - $20,000 [$1,000] The range is $1,000 - $20,000
Lifetime **Maximum Benefit Amount**	[$1,000,000.00]	[$10,000.00]	[$1,000,000] The range is $150,000-$5,000,000 [$10,000] The range is $2,500 - $500,000
Physical, Occupational, or Work Hardening Therapies	To a maximum combined [36] visits	[N/A]	[36] The range is 0 – 100 [N/A] The range is either N/A or the same as for Occupational Injuries
Ambulance for Medically Necessary Services	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**	[1] The range is 1 – 5 for both [$10,000] The range is $1,000-$25,000 for both
Acupuncture Care and Chiropractic Care	[$1,000.00] per **Injury**	N/A	[$1,000] The range is $1,000 - $25,000
[Hernia Coverage]	[$10,000.00]	N/A	[Hernia Coverage] will be in or out. If in: [$10,000] The range is $1,000 - $25,000
[Hemorrhoid Coverage]	[$10,000.00]	N/A	[Hemorrhoid Coverage] will be in or out. If in: [$10,000] The range is $1,000 - $25,000
Mental and Nervous or Depressive Condition	1 visit per day to a maximum of [$25.00] per visit and [20] visits per **Accident**	N/A	[$25] The range is $25 - $100 [20] The range is 10 - 100
[**Occupational Cumulative Trauma**]	[$20,000.00]	N/A	[**Occupational Cumulative Trauma**] will be in or out. If in: [$20,000] The range is $10,000 - $1,000,000
	Occupational Injuries	**Non-Occupational Injuries**	
[**Occupational Disease**]	[$20,000.00]	N/A	[**Occupational Disease**] will be in or out. If in: [$20,000] The range is $10,000 - $1,000,000

Temporary Total Disability Benefit:			
Commencement Period	[90 days]	[90 days]	[90 days] The range is 90 – 365 for both
Waiting Period	[7 days]	[7 days]	[7 days] The range is 0 – 30 for both
Benefit Percentage	[70.0%]	[70.0%]	[70.0%] The range is 60% - 80% for both
Minimum Weekly Benefit Amount	[$125.00]	[$125.00]	[$125] The range is $125 - $250 [$125] The range is $50 - $250
Maximum Weekly Benefit Amount	[$500.00]	[$500.00]	[$500] The range is $250 - $1,000 [$500] The range is $50 - $1,000
Maximum Benefit Period**	[104 weeks]	[12 weeks]	[104 weeks] The range is 52 – 260 [12 weeks] The range is 0 – 104
[**Maximum Benefit Period** for Hernia]	[90 days]	N/A	[90 days] The range is 30 – 365
[**Maximum Benefit Period** for Hemorrhoid]	[90 days]	N/A	[90 days] The range is 30 – 365
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**]	[90 days]	N/A	[90 days] The range is 90 - 365
[**Maximum Benefit Period** for **Occupational Disease**]	[90 days]	N/A	[90 days] The range is 90 - 365
Continuous Total Disability Benefit: ***			
Waiting Period	[equals **Maximum Benefit Period** for **Temporary Total Disability**]	N/A	[equals **Maximum Benefit Period** for **Temporary Total Disability**] will be in or out.
Benefit Percentage	[70.0%]	N/A	[70.0%] The range is 60% - 80%
Minimum Weekly Benefit Amount	[$50.00]	N/A	[$50] The range is $50 - $250
Maximum Weekly Benefit Amount	[$500.00]	N/A	[$500] The range is $250 - $1,000
Maximum Benefit Amount	[$300,000.00]	N/A	[$300,000] The range is $200,000 - $1,000,000
Maximum Benefit Period	Up to age 70, but not beyond full Social Security retirement age	N/A	
	Occupational Injuries	**Non-Occupational Injuries .**	
Additional Benefits:			
[Return of Remains Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.

[Non-Medical Repatriation Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[After School Care Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Coma Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Critical Burn Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Day Care Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Felonious Assault Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Higher Education Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Hijacking Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Vehicle Modification Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Seat Belt Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
[Spouse Retraining Benefit]	[Refer to SECTION VI]	N/A	This Additional Benefit will be in or out.
Limits of Liability:			
Combined Single Limit of Liability	[$1,000,000.00]	[$10,000.00]	[$1,000,000] The range is $500,000-$5,000,000 [$10,000] The range is $2,500 - $1,000,000
Aggregate Limit of Liability	[$2,000,000.00]	[$15,000.00]	[$2,000,000] The range is $500,000-$5,000,000 [$15,000] The range is $2,500 - $1,000,000
Sub Limits of Liability:			
[**Combined Single Limit of Liability** for:			
[Hernia]	[$20,000.00]	N/A	[$20,000] The range is $1,000 - $25,000
[Hemorrhoid]	[$20,000.00]	N/A	[$20,000] The range is $1,000 - $25,000
[**Occupational Disease**]	[$50,000.00]	N/A	[$50,000] The range is $10,000 - $1,000,000
[**Occupational Cumulative Trauma**]	[$50,000.00]	N/A	[$50,000] The range is $10,000 - $1,000,000
* Starting at age [65], the **Principal Sum** shall be based on the following schedule:			[65] The range is 65 - 70
Age at Date of Loss	Percent of **Principal Sum**		
[65]	[80%]		[65] The range is 65 – 70

		[80%] The range is 80% - 100%
[66]	[60%]	[66] The range is 66 – 71 [60%] The range is 60% - 100%
[67]	[40%]	[67] The range is 67 – 72 [40%] The range is 40% - 100%
[68]	[20%]	[68] The range is 68 – 73 [20%] The range is 20% - 100%
[69]	[15%]	[69] The range is 69 – 74 [15%] The range is 15% - 100%
[70 and over]	[10%]	[70 and over] The range is 75 and over [10%] The range is 10% - 100%
** If **You** suffer an **Injury** at or after age [70], the **Maximum Benefit Period** shall be [one (1) year].		[70] The range is 70 – 75 [one (1) year] The range is 1 - 3

SECTION II – GENERAL DEFINITIONS

Actively at Work means under **Dispatch** for at least [30] hours each week.	[30] The range is 15 - 30
Contract Driver means an individual who: 8. [has a valid and current commercial driver's license on the effective date of enrollment;] 9. [is authorized by an **Owner/Operator** to operate a power unit owned or leased by an **Owner/Operator** and must neither own nor lease the power unit;] 10. [is compensated on a basis other than time expended in the performance of work;] 11. [is responsible for determining the route and time for **Assignment**;] 12. [has the principal duty to operate the power unit;] 13. [is classified as an independent contractor by the **Policyholder** and the **Owner/Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance, or for any other purpose, [unless workers' compensation coverage is not mandatory for such person as an employee of either the **Policyholder** or **Owner/Operator**];] and 14. [receives for federal income tax reporting purposes a 1099 and not a W-2].	Any combination of 1. – 7. will be in or out.
Dependent Child(ren) means **Your** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption, who are: 1. under age 19 or under age 23 if he or she [:] [(a)] is enrolled in accredited institution of higher learning on a full-time basis, [and (b) relies on **You** for more than 50% of his or her support and is taken as a dependent on **Your** Federal Income Tax Return]; or 2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on **You** for support and maintenance as defined herein	(a) will be in or out (b) will be in or out
Dispatch means the time during which **You** are on **Assignment** or **You** are performing tasks prior to or after an **Assignment** to prepare	

the contracted vehicle for a current or future **Assignment**. **Dispatch** must be authorized by the **Policyholder** and includes the following: 1. in route to pick up a load; 2. picking up a load; 3. in route to delivering a load; 4. unloading a load; 5. the waiting time for a load; 6. returning from delivering a load; 7. in route to, returning from or performing a pre-trip inspection as required by a recognized governmental agency and/or the contracted motor carrier; 8. [while performing vehicle maintenance or repairs on the contracted vehicle during any of the foregoing times; and] 9. [while performing verifiable vehicle maintenance or repairs on the contracted vehicle; and] 10. performing activities to comply with federal or state laws or to satisfy contracted motor carrier requirements.	8. will be in or out. 9. will be in or out.
Owner/Operator means an individual who leases to or from the **Policyholder** and: 1. [has a valid and current commercial driver's license on the effective date of enrollment;] 2. [owns or leases a power unit;] 3. [is responsible for the maintenance and operating costs of the power unit, including, but not limited to fuel, repairs and supplies;] 4. [is compensated on a basis other than time expended in the performance of work;] 5. [is responsible for determining the route and time for **Assignment**;] 6. [has the right to select or reject the load;] 7. [has a written contract or **Assignment** from the **Policyholder** and is classified as an independent contractor by the **Policyholder** and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;] and 8. [receives for federal income tax reporting purposes a 1099 not a W-2].	Any combination of 1. – 8. will be in or out.
Policy means the [Truckers][Occupational] Accident Insurance Policy issued to the **Policyholder**.	[Truckers] will be in or out. [Occupational] will be in or out.
Waiting Period means the consecutive number of days **You** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Policy**. **Temporary Total Disability Benefits** and **Continuous Total Disability Benefits** are[not] retroactive to the first day of disability. The **Waiting Period** is shown in the **Schedule**.	[not] will be in or out.

SECTION III – EFFECTIVE DATES AND TERMINATION DATES

Policy Effective and Termination Dates 2. Policy Termination Date. The **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of: a. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**; b. the date specified in the written notice of **Our** intent to terminate the **Policy**, which will be at least [thirty (30)] days after the date **We** send such notice to the **Policyholder's** last known recorded address; c. the date specified in the written notice of the **Policyholder's**	[thirty (30)] The range is 30 – 90

intent to terminate the **Policy**, which will be at least [thirty (30)]days after the date the **Policyholder** sends such notice to **Us**; or d. at the expiration of the **Policy Period**.	[thirty (30)] The range is 30 - 90

SECTION IV - PREMIUMS

PREMIUMS Premiums are payable to **Us** in the amount shown in the **Schedule**. **We** may change the required premiums due by giving the **Policyholder** at least [sixty (60) days] advance written notice. **We** may change the required premiums as a condition of any renewal of the **Policy**. **We** may also change the required premiums at any time when any change affecting premiums is made in the **Policy**. **We** may re-underwrite and may change the terms and conditions of the **Policy** including the premium rate on the date when the number of **Insured Persons** under the **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [fifteen percent (15%)] or more. The **Policyholder** shall provide **Us** with written notice of such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.	[sixty (60) days] The range is 30 - 90 [fifteen percent (15%)] The range is 15% - 100% [thirty (30) days] The range is 30 - 90
PLAN AND EXPOSURE CHANGES The **Policyholder** must notify **Us** of any subsidiary or affiliated company that is to be covered under the **Policy**. Such notice must be sent within [thirty (30) days] of the acquisition of such subsidiary or affiliated company. If such notice is not provided, the newly acquired entity will not be considered a part of the **Policyholder** and the owner/operators or contract drivers will not be **Insured Persons** until the date that notice is provided. **We** have the right to decline coverage or adjust premium based on the changing exposure.	[thirty (30) days] The range is 30 - 90
YOUR GRACE PERIOD A grace period of [thirty-one (31) days] will be provided for the payment of **Your** Premium due after the first premium. **Your** coverage will not be terminated for non-payment of premium during this grace period if **You** pay the premium due by the last day of this grace period. **Your** coverage will terminate if the full amount of the premium due is not paid by the last day of this grace period.	[thirty-one (31) days] The range is 31 - 90
POLICY GRACE PERIOD A grace period of [thirty-one (31)] days will be provided for the payment of any premium due after the first premium. The **Policy** will not be terminated for nonpayment of premium during this grace period if the **Policyholder** pays all premiums due by the last day of this grace period. The **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of this grace period. No Policy Grace Period will be provided if **We** receive notice to terminate the **Policy** prior to a premium due date.	[thirty-one (31) days] The range is 31 - 90

SECTION V - BENEFITS

ACCIDENTAL DISMEMBERMENT BENEFIT If **Injury** to **You** results in any one of the **Losses** specified below within the **Commencement Period**, **We** will pay the Percentage of the **Principal Sum** shown below: For **Loss** of: — Percentage of the **Principal Sum** Both Hands or Both Feet — [100%]	[100%] The range is 50% - 100%

Sight of Both Eyes	[100%]	[100%] The range is 50% - 100%
One Hand and One Foot	[100%]	[100%] The range is 50% - 100%
One Hand and the Sight of One Eye	[100%]	[100%] The range is 50% - 100%
One Foot and the Sight of One Eye	[100%]	[100%] The range is 50% - 100%
One Hand or One Foot	[50%]	[50%] The range is 50% - 100%
Sight of One Eye	[50%]	[50%] The range is 50% - 100%
Thumb and Index Finger of Same Hand	[25%]	[25%] The range is 25% - 100%
Speech and Hearing	[50%]	[50%] The range is 25% - 100%
Speech or Hearing	[25%]	[25%] The range is 25% - 100%

PARALYSIS BENEFIT

If **Injury** to **You** results in any Type of Paralysis specified below within the **Commencement Period**, **We** will pay the Percentage of the **Principal Sum** shown below:

Type of Paralysis:	Percentage of the **Principal Sum**	
Quadriplegia	[100%]	[100%] The range is 50% - 100%
Paraplegia	[75%]	[75%] The range is 25% - 100%
Hemiplegia	[50%]	[50%] The range is 25% - 100%
Uniplegia	[25%]	[25%] The range is 25% - 100%

TEMPORARY TOTAL DISABILITY BENEFIT

If **Injury** to **You** results in **Temporary Total Disability** within the **Commencement Period** and **You** are under age [70] on the day the **Temporary Total Disability** begins, **We** will pay the following amount, after the **Waiting Period**:

For this benefit, the following definitions apply:

Average Weekly Earnings means:

1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income **You** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If You sustains an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who are contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation.]

   This will be in or out. If in:
   [Thirty-three percent (33%)] The range is 25% - 75%

   [Thirty-three percent (33%)] The range is 25% - 75%

   [Thirty-three percent (33%)] The range is 25% - 75%

   [Thirty-three percent (33%)] The range is 25% - 75%

2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income **You** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [seventy-five percent (75%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** is

   This will be in or out. If in:
   [Seventy-five percent (75%)] The range is 25% - 75%

   [Seventy-five percent (75%)] The range is 25% - 75%

   [Seventy-five percent (75%)] The range is 25% - 75%

unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [seventy-five percent (75%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation provided **You** were not an **Owner/Operator**. If **You** were an **Owner/Operator**, then **We** will use 33% of the gross income.]	[Seventy-five percent (75%)] The range is 25% - 75%
Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the **Maximum Weekly Benefit Amount**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.	[seventy percent (70%)] The range is 60% - 80%
Temporary Total Disability or Temporarily Totally Disabled means disability that: 2. prevents **You** from performing the **Material and Substantial Duties** of **Your** occupation [as a commercial truck driver];	[as a commercial truck driver] will be in or out.
CONTINUOUS TOTAL DISABILITY BENEFIT If **Injury** to **You** resulting in **Temporary Total Disability** subsequently results in **Continuous Total Disability**, **We** will pay the following, after the **Waiting Period**: 1. for each month of a **Continuous Total Disability**, the Continuous Total Disability Benefit is four and three-tenths (4.3) times the **Weekly Benefit Amount** for **Temporary Total Disability**; or 2. for less than a full **Benefit Week** of **Continuous Total Disability**, the Continuous Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Continuous Total Disability**, but only if: a. Temporary Total Disability Benefits ceased solely because the **Maximum Benefit Period** has been reached, but the **Insured Person** remains disabled; b. the **Insured Person** is not within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration, on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached; c. the **Insured Person** has been granted a Social Security disability award for his or her disability (if the **Insured Person** cannot meet the credit requirement for a Social Security disability award he or she cannot qualify for the Continuous Total Disability Benefit even if he or she would otherwise qualify); d. the **Insured Person's** disability is reasonably expected to continue without interruption until he or she dies and is substantiated by objective medical evidence satisfactory to the **Company**; e. the **Injury** resulting in a **Continuous Total Disability** occurred before the **Insured Person** is within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration; [and] f. the **Injury** began within the **Commencement Period** [.] [; and] g. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**.] For this benefit, the following definitions apply: **Average Weekly Earnings** will be calculated as follows: 1. [for **Owner/Operators**:	g. will be in or out This will be in or out. If in:

[Thirty-three percent (33%)] of the gross income **You** received, less fuel surcharges, in the twelve (12) weeks prior to the Injury, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [thirty-three percent (33%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation.]	[Thirty-three percent (33%)] The range is 25% - 75% [Thirty-three percent (33%)] The range is 25% - 75% [Thirty-three percent (33%)] The range is 25% - 75% [Thirty-three percent (33%)] The range is 25% - 75%
2. [for **Contract Drivers**: [Seventy-five percent (75%)] of the gross income **You** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [seventy-five percent (75%)] of the average gross income received by the other **Insured Persons**, who were contracted within the last three (3) months prior to the covered **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [seventy-five percent (75%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation provided **You** were not an **Owner/Operator**. If **You** were an **Owner/Operator**, then **We** will use 33% of the gross income.]	This will be in or out. If in: [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75% [Seventy-five percent (75%)] The range is 25% - 75%
Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the Maximum Weekly Benefit. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.	[seventy percent (70%)] The range is 60% - 80%
ACCIDENT MEDICAL EXPENSE BENEFIT **Home Health Care** means nursing care and treatment of **You** in **Your** home as part of a treatment plan prescribed by the attending **Physician**, which is provided by a **Hospital** or agency certified to provide such services, but only if it:	
1. begins within [seven (7)] days after discharge from a **Hospital**; and	[seven (7)] The range is 1 - 30
2. follows a **Hospital** confinement of [five (5)] days or more.	[five (5)] The range is 1 – 30
Usual and Customary Charge(s) means an amount(s) that: 1. does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and	

2. does not include charges that would not have been made if no insurance existed[; and 3. does not exceed the cost of a generic drug, if available. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available].	[seventy-five percent (75%)] The range is 25% - 100%
ACCIDENT MEDICAL EXPENSE BENEFIT EXCLUSIONS In addition to the General Exclusions and Limitations in Section VIII of the **Policy**, **Medically Necessary Services or Charges** do not include expenses for or resulting from any of the following:	
9. any expenses covered by [Medicare, Medicaid,] a **Third Party** [or any other insurance]; 13. an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;	[Medicare, Medicaid,] will be in or out [or any other insurance] will be in or out [five (5)] The range is 1 - 10

SECTION VI - ADDITIONAL BENEFITS

[**RETURN OF REMAINS BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay for the transport of **Your** body or remains (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of **Your** body or remains to **Your** county of residence. **We** must be contacted prior to the transportation of **Your** body or remains and **We** must pre-authorize the transportation for coverage to apply. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]	This Additional Benefit will be in or out. If in: [one thousand dollars ($1,000)] The range is $250 - $2,500
[**NON-MEDICAL REPATRIATION BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accident Medical Expense Benefit and have sufficiently recovered to travel in a regularly scheduled economy class air flight, commercial bus or train and without special medical equipment or personnel with a minimal risk to **Your** health, **We** will pay for the return to **Your** principal residence. **We** must be contacted prior to the transport and **We** must agree to the travel itinerary for coverage to apply. This benefit is subject to the prior recommendation of the attending **Physician**. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]	This Additional Benefit will be in or out. If in: [one thousand dollars ($1,000)] The range is $250 - $2,500
[**AFTER SCHOOL CARE BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit for after school care to the individual who incurs the expense on behalf of each **Dependent Child** who is [ten (10)] years old or less, up to a maximum of the lesser of: 1. [two percent (2%)] of the applicable **Principal Sum** paid under the Accidental Death Benefit per year; or 2. [two thousand dollars ($2,000)] per year. The after school care provider may not be an **Immediate Family Member** and written proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, to establish continued eligibility for this benefit. This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child** is under age [ten (10)] at the time of each payment. [The maximum amount payable under this benefit for all children	This Additional Benefit will be in or out. If in: [ten (10)] The range is 3 - 16 [two percent (2%)] The range will be 1% - 3% [two thousand dollars ($2,000)] The range will be $1,500 - $5,000 [four (4)] The range will be 1 - 8 [ten (10)] The range will be 3 - 16 This will be in or out. If in:

combined is [eight thousand dollars ($8,000)].]	[eight thousand dollars ($8,000)] The range is $4,000 - $12,000
[**COMA BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** and within three hundred sixty five (365) days of the **Accident** which caused such **Injury**, such **Injury** causes **You** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay an additional benefit equal to [one percent (1%)] of the **Principal Sum** for such **Injury**, and such amount will be paid each month **You** remain in a **Coma** following the initial thirty-one (31) day period. At the end of eleven (11) months of payment, if **You** remain in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the eleven (11) months of benefit already received. The Coma Benefit will end on the earliest of the following: 1. the date **You** are no longer in the **Coma**; or 2. the date **You** have received a Coma Benefit for eleven (11) months. **We** may require receipt of written proof, at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit. For this benefit, the following definition applies: **Coma** means a condition determined as such by **Our** duly licensed **Physician**.]	This Additional Benefit will be in or out. If in: [one percent (1%)] The range is 1% - 5%
[**CRITICAL BURN BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss**, **We** will pay an additional benefit equal to the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)], but only if **You**: 1. suffered second degree or higher burns over [twenty-five percent (25%)] of **Your** body; and 2. have undergone reconstructive surgery to treat the burned areas of **Your** body within three hundred sixty-five (365) days of the occurrence of the **Accident** that caused the **Injury**.]	This Additional Benefit will be in or out. If in: [ten percent (10%)] The range is 5% - 25% [ten thousand dollars ($10,000)] The range is $5,000 - $30,000 [twenty-five percent (25%)] The range is 10% - 50%
[**DAY CARE BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense for each **Dependent Child** if: 1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and 2. the **Dependent Child** is under age [thirteen (13)]. The Day Care Benefit will be equal to the lesser of: 1. the actual cost of the day care; 2. [three percent (3)%] of the **Principal Sum**; or 3. [three thousand dollars ($3,000)]; and will be paid annually for [four (4)] consecutive years if: 1. the **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and 2. written proof acceptable to **Us** is received by **Us** at such intervals	This Additional Benefit will be in or out. If in: [ninety (90)] The range is 30 - 180 [thirteen (13)] The range is 1 - 16 [three percent (3)%] The range is 1% - 5% [three thousand dollars ($3,000)] The range is $1,000 - $6,000 [four (4)] The range is 1 - 8 [thirteen (13)] The range is 1 - 16

as **We** may reasonably require, establishing continued eligibility for this benefit. For this benefit, the following definition applies: **Accredited Child Care Facility** means a properly licensed childcare facility that operates pursuant to state and local laws and has a Tax Identification Number issued by the Internal Revenue Service. **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]	This will be in or out. If in: [eight thousand dollars ($8,000)] The range is $1,000 - $20,000
[**FELONIOUS ASSAULT BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** for an **Occupational Injury** payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Paralysis Benefit as a result of a **Felonious Assault** by someone other than **Yourself**, **You** or an **Immediate Family Member** or **Household Member**, **We** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum**, but only if: 1. the **Felonious Assault** occurs while **You** are under **Dispatch**; and 2. the crime directly involves the **Policyholder's** or **Your** funds or assets. For this benefit, the following definition applies: **Felonious Assault** means the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]	This Additional Benefit will be in or out. If in: [ten percent (10%)] The range is 5% - 25%
[**HIGHER EDUCATION BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay a benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**, but only if on the date of the **Accident**, the **Dependent Child**: 3. is enrolled as a full-time student in an accredited college, university or trade school; or 4. is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**. The Higher Education Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit. [The maximum amount payable under this benefit for all **Dependent Child(ren)** combined is [twenty thousand dollars ($20,000)].]]	This Additional Benefit will be in or out. If in: [five percent (5%)] The range is 3% - 10% [five thousand dollars ($5,000)] The range is $2,500 - $10,000 [four (4)] The range is 1 - 6 This will be in or out. If in: [twenty thousand dollars ($20,000)] The range is $10,000 - $30,000
[**HIJACKING BENEFIT** The exclusion for war or any acts of war whether declared or	This Additional Benefit will be in or out.

undeclared as found in Section VIII General Exclusions and Limitations of the **Policy** is modified and an **Injury** directly resulting from a **Hijacking** or any attempt at any **Hijacking** is covered under the **Policy**. This benefit will continue beyond the actual **Hijacking** while **You** are: 1. subject to the control of the person(s) making the **Hijacking**; and 2. traveling directly to **Your** home or original destination. For this benefit, the following definition applies: **Hijacking** means the unlawful seizure or wrongful exercise of control of a power unit occupied by **You**, while **You** are getting into, riding in, or getting out of and while under **Dispatch**.]	
[**VEHICLE MODIFICATION BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Dismemberment Benefit or Paralysis Benefit, **We** will pay an additional benefit equal to the actual cost for modifications to **Your** motor vehicle that are necessary to make it accessible or drivable, but only if such **Injury** requires **You** to use a wheelchair. Benefits are not payable unless: 1. the modifications are made by a person(s) experienced in such modifications and are recommended by an organization recognized for providing support and assistance to wheelchair users; and 2. proof sufficient to **Us** is received by **Us**, establishing eligibility for this benefit. The maximum amount payable under this benefit will be the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)].]	This Additional Benefit will be in or out. If in: [ten percent (10%)] The range is 3% - 10% [ten thousand dollars ($10,000)] The range is $3,000 - $25,000
[**SEAT BELT BENEFIT** If **You** suffer an **Injury** directly resulting from an automobile **Accident** resulting in a **Covered Loss** payable under the Accidental Death Benefit or Survivor's Benefit, **We** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum** up to a maximum of [ten thousand dollars ($10,000)], but only if **You** were: 1. operating or riding as a passenger in a motorized vehicle designed for use primarily on public roads; and 2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Accident**. **Your** actual use of the seat belt or lap and shoulder restraints must be verified in the official law enforcement report of the **Accident**, through certification by the investigating officers; or by other reasonable proof, acceptable to **Us**.]	This Additional Benefit will be in or out. If in: [ten percent (10%)] The range is 5% - 25% [ten thousand dollars ($10,000)] The range is $5,000 - $25,000
[**SPOUSE RETRAINING BENEFIT** If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit to **Your Spouse** for the actual cost of any state licensed professional or trade-training program in which **Your Spouse** enrolls and completes, but only if the purpose of the program is to obtain an independent source of support and maintenance and the actual cost is incurred within [thirty (30)] months from **Your** death.	This Additional Benefit will be in or out. If in: [thirty (30)] The range is 1 - 180

The Spouse Retraining Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if **Your Spouse** continues his or her training. Before this benefit is paid each year, proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit. [The maximum amount payable under this benefit is [twenty thousand dollars ($20,000)].]	[five percent (5%)] The range is 3% - 10% [five thousand dollars ($5,000)] The range is $2,500 - $20,000 [four (4)] The range is 1 - 6 This will be in or out. If in: [twenty thousand dollars ($20,000)] The range is $2,500 - $30,000

SECTION VII - LIMITS OF LIABILITY

Limitation on Multiple Benefits. If **You** can recover benefits under two or more of the Accidental Death Benefit, Accidental Dismemberment Benefit, [Coma Benefit] or the Accidental Paralysis Benefit as a result of the same **Accident**, **We** will pay only up to the highest applicable **Principal Sum**.	[Coma Benefit] will be in or out

SECTION VIII - GENERAL EXCLUSIONS AND LIMITATIONS

The **Policy** does not cover any losses contributed to or caused by, in whole or in part, by any of the following: 1. [suicide or any attempt at suicide; intentionally self-inflicted Injury or any attempt at intentionally self-inflicted **Injury** or any **Injury** resulting from a provoked attack;] 2. [sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning [or routine and temporary non chronic sickness or illness such as a cold, cough, headache or nausea];] 3. [a **Pre-existing Condition**, until **You** have been continuously covered under the **Policy** for [twelve (12)] consecutive months;] 4. [**Occupational Cumulative Trauma** or **Cumulative Trauma and Repetitive Conditions**, unless shown in the **Schedule**;] 5. [**Occupational Disease**, unless shown in the **Schedule**;] 6. [performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;] 7. [declared or undeclared war, or any act of declared or undeclared war;] 8. [full-time active duty in the armed forces of any country or international authority;] 9. [any **Injury** for which **You** are entitled to benefits pursuant to any workers' compensation law or other similar legislation;] 10. [any loss insured by employers' liability insurance;] 11. [**You** being intoxicated: a. **You** are conclusively deemed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether You are in fact operating a motor vehicle when the **Injury** occurs; and b. an autopsy report from a licensed medical examiner, law enforcement officer reports or similar items will be considered proof of **Your** intoxication;] 12. [**You** being under the influence of any illegal substance, drug, narcotic, or hallucinogen, unless such drug, narcotic, or	Any combination of 1. – 16. may be in or out. If in: [twelve (12)] The range is 6 - 24

hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage;] 13. [**Your** commission of or attempt to commit a felony or a Class A misdemeanor;] 14. [travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if **You** are: a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or **You**;] 15. [skydiving, parasailing, hang-gliding, bungee-jumping [or any similar activity];] [or] 16. [charges incurred for treatment of a covered **Injury**, when **You** obtain compensation for the covered **Injury** from a **Third Party**].	
[INCARCERATION LIMITATION Benefits provided to **You** will cease while **You** are incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when **You** are released from such facility.]	This will be in or out.

SECTION IX - CLAIM PROVISIONS

NOTICE OF CLAIM Written notice of claim must be received by **Us** within twenty (20) days after **Your** loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to **Us** at Zurich American Insurance Company Group Accident Claims Division, [P.O. Box 968041 Schaumburg, IL 60196] with information sufficient to identify **You**, is deemed notice to **Us**.	The Company's mailing address is variable in the event it changes.
SUNSET In no event shall benefits under the **Policy** be payable unless written Proof of Loss is received by **Us** within [three (3) years] from the date of the **Accident**.	[three (3) years] The range is 3 - 10
[**ARBITRATION** Any contest to a claim denial under the **Policy** shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration shall occur at the offices of the American Arbitration Association nearest to **You** or the person claiming to be the beneficiary. The arbitrator(s) shall not award consequential or punitive damages in any arbitration under this section. This provision does not apply if **You** or the person claiming to be the beneficiary is a citizen of a state where the law does not allow binding arbitration in an insurance policy but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. [Non-binding arbitration is required and no legal action may be brought by **You**, the beneficiary, or Us until thirty (30) days after the arbitrator(s) issues a non-binding award.] This provision bars the institution of any individual or class action lawsuit brought by **You** or the beneficiary.]	This provision will be in or out. If in: This will be in or out.

SECTION X - GENERAL PROVISIONS

POLICYHOLDER RECORDS The **Policyholder** will keep a record of the coverage, premium,	

beneficiary designation and other pertinent administrative information for each **Insured Person** which, if acceptable to **Us**, shall be deemed to be a part of the **Policy**. **We** may examine these records at any reasonable time while the **Policy** is in force and for six (6) years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured Person**. [The **Policyholder** shall indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the administration described herein.]	This will be in or out.
[**MADE WHOLE DOCTRINE** **We** have the right to recover any and all first monies paid (or payable) to or on behalf of **You** and to any and all claims of or on behalf of **You**, to the extent of benefits paid by the **Policy**, and regardless of whether or not the beneficiary has been made whole. Made whole shall include first dollar recovery with no offset for attorneys' fees.]	This provision will be in or out.
[**CLAIMS FOR WORKERS' COMPENSATION AND OTHER INSURANCE** No benefits shall be payable under the **Policy** for any loss for which **You** claim or file for any workers' compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, **We** shall determine **Our** liability under the **Policy**. **We** reserve the right to recover, from **You**, any benefits paid under the **Policy** that are subsequently paid for under any workers' compensation, employers' liability, occupational disease or similar law or any other insurance.]	This provision will be in or out.
[Workers' Compensation Indemnification. If **You** are determined by a court of law or the appropriate state regulatory authority to be covered under workers' compensation insurance for a **Covered Loss**, any benefits for which **You** are eligible under the **Policy**, are payable to the person who was determined to be **Your** employer or such person's designee or assignee.]	This provision will be in or out.

SECTION XI – IMPORTANT NOTICE

You may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if You need assistance in resolving any complaints. Or, You may write to Zurich American Insurance Company at their administrative offices at [XXXXXX]. **Should You wish to contact the Arkansas Insurance Department for assistance, You may do so by calling [1-800-282-9134]. Or, You may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].**	The appropriate telephone number will be inserted. The appropriate mailing address will be inserted. This is variable in the event of a change. This is variable in the event of a change.

ADMINISTRATIVE CHANGE ENDORSEMENT – U-OA-404-A CW (08/09)

[This endorsement will be used to make the following types of administrative changes to the **Policy/Certificate** at the Policyholder's request: 1. Policyholder's Name or Address; 2. Addition or deletion of subsidiaries or affiliates of the Policyholder; 3. Changes to the class(es) of eligible persons; 4. Addition or deletion of Benefit(s); 5. Increase or decrease in Benefit Amount(s); 6. Addition or deletion of Additional Benefit(s); 7. Increase or decrease in Additional Benefit Amount(s); or 8. Annual audit requirements.]	This endorsement will be used to make administrative changes to the Policy/Certificate.

[Truckers] [Occupational] Accident Insurance Policy

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

This **Policy** is a legal contract between the **Policyholder** and the **Company**. The **Company** agrees to insure eligible persons of the **Policyholder** (herein called **Insured Person(s)**) against loss covered by this **Policy**, subject to its provisions, limitations and exclusions. The persons eligible to be **Insured Persons** are all persons described in the eligibility section of the **Schedule**.

This **Policy** is issued in consideration of the payment of the required premium when due and the statements set forth in the signed Group Application, which is attached to and made part of this **Policy** and in the individual enrollment forms, if any.

This **Policy** begins on the Policy Effective Date shown in the **Schedule**. This **Policy** will continue in effect, provided premiums are paid when due, until the Policy Termination Date set forth in the **Policy**, unless otherwise terminated as further provided in this **Policy**, or renewed.

Please refer to the **Policy** for the special meaning of words and phrases that appear in bold.

Various provisions in this **Policy** restrict coverage. Read the entire **Policy** carefully to determine an **Insured Person's** rights and duties and what is and is not covered.

THIS POLICY PROVIDES ACCIDENT COVERAGE ONLY
THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

IMPORTANT NOTICE
THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.

This **Policy** is governed by the laws of the state in which it is delivered.

In return for the payment of premium, and subject to the terms of this **Policy**, coverage is provided as stated in this **Policy**.

IN WITNESS WHEREOF, this **Company** has executed and attested these presents and, where required by law, has caused this **Policy** to be countersigned by its duly Authorized Representative(s).

Nancy D. Mueller

President

Corporate Secretary

PLEASE READ THIS POLICY CAREFULLY

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THIS POLICY IS NOT WORKERS' COMPENSATION AND DOES NOT REQUIRE PRE-AUTHORIZATION OF A PHYSICIAN FOR COVERED SERVICES OR TREATMENT. THE INSURED PERSON MAY CONSULT THE COMPANY AT [1-888-889-5330] TO DETERMINE IF A SERVICE OR TREATMENT IS COVERED. THE COMPANY CAN PROVIDE THE INSURED PERSON WITH THE NAME AND ADDRESS OF A PHYSICIAN WHO IS A PREFERRED PROVIDER.

THE **INSURED PERSON** CANNOT BE COVERED BY ANY OTHER OCCUPATIONAL ACCIDENT POLICY ISSUED BY THE **COMPANY**. IF THE **INSURED PERSON** PAYS PREMIUM BUT IS NOT ELIGIBLE FOR COVERAGE OR DOES NOT QUALIFY FOR BENEFITS UNDER THIS **POLICY**, THE **COMPANY** WILL REFUND ANY UNEARNED PREMIUM PAID IN ERROR.

SECTION I - SCHEDULE

Policy Effective Date: [01/01/09]
[**Policy Period**: [01/01/09] to [01/01/10]]
Policy Premium Due Date: [01/01/09]
Policy Number: [XXXXXX-XX]

Insured Person's Premium: [$0.00]

Policyholder: [Name of Trucking Company]
[Address]
[City, State, Zip]

Eligible Persons

The following persons are eligible to become **Insured Persons** under this **Policy**:

CLASS I: **Actively at Work Owner/Operators** who have enrolled for coverage under this **Policy**.
CLASS II: **Actively at Work Contract Drivers** who have enrolled for coverage under this **Policy**.

Benefits Summary

	Occupational Injuries	**Non-Occupational Injuries**
☐ Accidental Death Benefit:		
Principal Sum*	[$50,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Survivor's Benefit:		
Principal Sum*	[$175,000.00]	[$7,500.00]
Monthly Benefit Percentage of **Principal Sum**	[1.0%]	[1.0%]
Monthly Benefit Amount	[$1,750.00]	[$1,750.00]
☐ Accidental Dismemberment Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accidental Paralysis Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accident Medical Expense Benefit:		
Commencement Period	[90 days]	[90 days]
Deductible Amount	[$0.00]	[$0.00]
Maximum Benefit Amount	[$1,000,000.00]	[$5,000.00]
Maximum Benefit Period	[104 weeks]	[52 weeks]
Dental Benefit Maximum	[$2,500.00]	[$1,000.00]
Lifetime **Maximum Benefit Amount**	[$1,000,000.00]	[$10,000.00]
Physical, Occupational, or Work Hardening Therapies	To a maximum-combined [36] visits	[N/A]
Ambulance for Medically Necessary Services	[1] round trip to and from a **Hospital** to a Maximum	[1] round trip to and from a **Hospital** to a Maximum

	Occupational Injuries of [$10,000.00] per **Accident**	**Non-Occupational Injuries** of [$10,000.00] per **Accident**
Acupuncture Care and Chiropractic Care	[$1,000.00] per **Injury**	N/A
[Hernia Coverage]	[$10,000.00]	N/A
[Hemorrhoid Coverage]	[$10,000.00]	N/A
Mental and Nervous or Depressive Condition	1 visit per day to a maximum of [$25.00] per visit and [20] visits per **Accident**	N/A
[**Occupational Cumulative Trauma**]	[$20,000.00]	N/A
[**Occupational Disease**]	[$20,000.00]	N/A

☐ Temporary Total Disability Benefit:

Commencement Period	[90 days]	[90 days]
Waiting Period	[7 days]	[7 days]
Benefit Percentage	[70.0%]	[70.0%]
Minimum Weekly Benefit Amount	[$125.00]	[$125.00]
Maximum Weekly Benefit Amount	[$500.00]	[$500.00]
Maximum Benefit Period**	[104 weeks]	[12 weeks]
[**Maximum Benefit Period** for Hernia]	[90 days]	N/A
[**Maximum Benefit Period** for Hemorrhoid]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Disease**]	[90 days]	N/A

☐ Continuous Total Disability Benefit: ***

Waiting Period	[equals **Maximum Benefit Period** for **Temporary Total Disability**]	N/A
Benefit Percentage	[70.0%]	N/A
Minimum Weekly Benefit Amount	[$50.00]	N/A
Maximum Weekly Benefit Amount	[$500.00]	N/A
Maximum Benefit Amount	[$300,000.00]	N/A
Maximum Benefit Period	Up to age 70, but not beyond full Social Security retirement age	N/A

☐ Additional Benefits: N/A

[Return of Remains Benefit]	[Refer to SECTION VI]	N/A
[Non-Medical Repatriation Benefit]	[Refer to SECTION VI]	N/A
[After School Care Benefit]	[Refer to SECTION VI]	N/A
[Coma Benefit]	[Refer to SECTION VI]	N/A
[Critical Burn Benefit]	[Refer to SECTION VI]	N/A
[Day Care Benefit]	[Refer to SECTION VI]	N/A
[Felonious Assault Benefit]	[Refer to SECTION VI]	N/A
[Higher Education Benefit]	[Refer to SECTION VI]	N/A
[Hijacking Benefit]	[Refer to SECTION VI]	N/A
[Vehicle Modification Benefit]	[Refer to SECTION VI]	N/A
[Seat Belt Benefit]	[Refer to SECTION VI]	N/A
[Spouse Retraining Benefit]	[Refer to SECTION VI]	N/A

Limits of Liability:

Combined Single Limit of Liability	[$1,000,000.00]	[$10,000.00]
Aggregate Limit of Liability	[$2,000,000.00]	[$15,000.00]

Sub Limits of Liability:

	Occupational Injuries	Non-Occupational Injuries
[**Combined Single Limit of Liability** for:		
[Hernia]	[$20,000.00]	N/A
[Hemorrhoid]	[$20,000.00]	N/A
[**Occupational Disease**]	[$50,000.00]	N/A
[**Occupational Cumulative Trauma**]	[$50,000.00]	N/A

* Starting at age [65], the **Principal Sum** shall be based on the following schedule:

Age at Date of Loss	Percent of **Principal Sum**
[65]	[80%]
[66]	[60%]
[67]	[40%]
[68]	[20%]
[69]	[15%]
[70 and over]	[10%]

** If an **Insured Person** suffers an **Injury** at or after age [70], the **Maximum Benefit Period** shall be [one (1) year].

*** If an **Insured Person** sustains an **Injury** within six months or less of attaining his or her full Social Security retirement age, as defined by the United States Social Security Administration, the **Insured Person** does not qualify for the Continuous Total Disability Benefit.

SECTION II - GENERAL DEFINITIONS

Accident means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while coverage is in effect under the **Policy**.

Actively at Work means under **Dispatch** for at least [30] hours each week.

Aggregate Limit of Liability shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

Assignment means the **Policyholder** has offered and the **Insured Person** has accepted a shipment of freight as recorded in the books and records of the **Policyholder** in the ordinary course of business.

Company means Zurich American Insurance Company.

Co-Owner means a person who has partial ownership of a vehicle operating as an **Owner/Operator**.

Combined Single Limit of Liability means, with respect to any one **Insured Person**, the maximum amount that the **Company** will pay for all **Covered Loss** under this **Policy** for or in connection with **Injury** to an **Insured Person** resulting from any one **Accident**. When the **Combined Single Limit of Liability** has been reached, no further benefits shall be payable under this **Policy**, with respect to that **Insured Person**, for or in connection with **Injury** sustained as the result of that one **Accident**.

Commencement Period means the period between the date of the **Accident** that caused the **Injury** and the date on which the **Covered Loss** must occur for benefits to be payable under the Accidental Death Benefit, the Accidental Dismemberment Benefit, Accidental Paralysis Benefit, Accident Medical Expense Benefit and/or the Temporary Total Disability Benefit.

Contract Driver means an individual who:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [is authorized by an **Owner/Operator** to operate a power unit owned or leased by an **Owner/Operator** and must neither own nor lease the power unit;]
3. [is compensated on a basis other than time expended in the performance of work;]

4. [is responsible for determining the route and time for **Assignment**;]
5. [has the principal duty to operate the power unit;]
6. [is classified as an independent contractor by the **Policyholder** and the **Owner/Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance, or for any other purpose, [unless workers' compensation coverage is not mandatory for such person as an employee of either the **Policyholder** or **Owner/Operator**];] and
7. [receives for federal income tax reporting purposes a 1099 and not a W-2].

Covered Loss, in the singular or plural, means one or more of the losses or expenses identified in Sections V and VI of this **Policy** that are not specifically excluded herein.

Cumulative Trauma or Repetitive Conditions means **Non-Occupational** conditions that impair the normal physiological function of the body over an extended period, but do not arise as the result of a single **Accident**.

Dependent Child(ren) means the **Insured Person's** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption, who are:
1. under age 19 or under age 23 if he or she [:] [(a)] is enrolled in accredited institution of higher learning on a full-time basis, [and (b) relies on the **Insured Person** for more than 50% of his or her support and is taken as a dependent on the Federal Income Tax Return of the **Insured Person**]; or
2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the **Insured Person** for support and maintenance as defined herein.

The **Company** may require proof of the **Dependent Child(ren)'s** incapacity and dependency before the **Dependent Child(ren)** reached the age limit specified above. The **Company** may request that satisfactory proof of the **Dependent Child(ren)'s** continued incapacity and dependency be submitted to the **Company** on an annual basis.

Deleted: within 60 days

Dispatch means the time during which an **Insured Person** is on **Assignment** or is performing tasks prior to or after an **Assignment** to prepare the contracted vehicle for a current or future **Assignment**. **Dispatch** must be authorized by the **Policyholder** and includes the following:
1. in route to pick up a load;
2. picking up a load;
3. in route to delivering a load;
4. unloading a load;
5. the waiting time for a load;
6. returning from delivering a load;
7. in route to, returning from or performing a pre-trip inspection as required by a recognized governmental agency and/or the contracted motor carrier;
8. [while performing vehicle maintenance or repairs on the contracted vehicle during any of the foregoing times; and]
9. [while performing verifiable vehicle maintenance or repairs on the contracted vehicle; and]
10. performing activities to comply with federal or state laws or to satisfy contracted motor carrier requirements.

Eligible Person(s) means a Class I or Class II individual described in the **Schedule**.

Household Member means a person who maintains residence at the same address as the **Insured Person** and is not an **Immediate Family Member**.

Immediate Family Member means an **Insured Person's Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, stepparent, brother, sister, stepbrother, stepsister, child, child who has been legally adopted, or stepchild.

Injury, in the singular or plural, means bodily injury caused by an **Accident**, which occurs while the **Insured Person** is covered under this **Policy** and the **Injury** must result directly and independently of all other causes, in a **Covered Loss**. All **Injuries** sustained by an **Insured Person** in any one **Accident** shall be considered a single **Injury**.

Insured Person(s) means an **Owner/Operator** or **Contract Driver**:
1. who is enrolled for coverage under this **Policy**;
2. who has paid the required premium when due; and
3. whose coverage is in effect under this **Policy**.

Maximum Benefit Amount means the maximum amount that the **Company** will pay under the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Amount** is shown in the **Schedule**.

Maximum Benefit Period means the maximum period that the **Company** will pay benefits, after the **Waiting Period**, under the Temporary Total Disability Benefit, the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Period** is shown in the **Schedule**.

Maximum Weekly Benefit Amount means the maximum amount that the **Company** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Maximum Weekly Benefit Amount** is shown in the **Schedule**.

Mental and Nervous or Depressive Condition means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.

Minimum Weekly Benefit Amount means the minimum amount that the **Company** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Minimum Weekly Benefit Amount** is shown in the **Schedule**.

Non-Occupational means benefits payable for an **Injury** due to an **Accident** sustained by an **Insured Person** while not under **Dispatch**.

Occupational means, with respect to an activity, **Accident**, incident, circumstance or condition involving an **Insured Person**, that the activity, **Accident**, incident, circumstance or condition occurs or arises out of or in the course of the **Insured Person** performing services within the course and scope of contractual obligations for the **Policyholder**, and while under **Dispatch**. **Occupational** does not encompass any period during the course of everyday travel to and from work, other than as allowed under **Dispatch**, or while on vacation.

Occupational Assessment means a test of vocational capabilities, including review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), and evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

Occupational Cumulative Trauma means bodily injury that impairs the normal physiological function of the body caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time and does not arise as the result of a single **Accident**, when:
1. such condition is diagnosed by a **Physician**;
2. the **Insured Person's** last day of last performance of the activities causing the bodily injury occurred while the **Insured Person's** coverage is in effect; and
3. such bodily injury resulted directly, and independently of all other causes, in a **Covered Loss**.

Occupational Disease means a sickness that results in disability or death, and is caused by exposure to environmental or physical hazards during the course of the **Insured Person's Occupational** activities, when:
1. such sickness is diagnosed by a **Physician** and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards;
2. exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which the **Insured Person** performs **Occupational** activities;
3. the **Insured Person's** last day of last exposure to the environmental or physical hazards causing such sickness occurs while the **Insured Person's** coverage is in effect; and
4. such exposure results directly and independently of all other causes in a **Covered Loss**.

Owner/Operator means an individual who leases to or from the **Policyholder** and:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [owns or leases a power unit;]
3. [is responsible for the maintenance and operating costs of the power unit, including, but not limited to fuel, repairs and supplies;]
4. [is compensated on a basis other than time expended in the performance of work;]
5. [is responsible for determining the route and time for **Assignment**;]
6. [has the right to select or reject the load;]

7. [has a written contract or **Assignment** from the **Policyholder** and is classified as an independent contractor by the **Policyholder** and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;] and
8. [receives for federal income tax reporting purposes a 1099 not a W-2].

Physician means a qualified medical doctor acting within the scope of his or her license who is not:
1. the **Insured Person**;
2. an **Immediate Family Member**;
3. a **Household Member**; or
4. a practitioner retained by the **Policyholder**.

Policy means this [Truckers] [Occupational] Accident Insurance Policy.

Policyholder means the entity named as **Policyholder** in the **Schedule**.

Policy Period means the period shown in the **Schedule**, subject to prior termination pursuant to Section III of this **Policy**.

Pre-Existing Condition means a condition for which an **Insured Person** has sought or received medical advice or treatment at any time during the twelve months immediately preceding his or her effective date of coverage under this **Policy**.

Principal Sum means the maximum amount that the **Company** will pay under the Accidental Death Benefit, the Survivor's Benefit, the Accidental Dismemberment Benefit or the Accidental Paralysis Benefit. The applicable **Principal Sum** is shown in the **Schedule** and is subject to the **Combined Single Limit of Liability** and the **Aggregate Limit of Liability**.

Schedule means SECTION I of this **Policy**.

Spouse means the **Insured Person's** legal spouse.

Third Party in the singular or plural means, but is not limited to, the following:
1. the party that caused the **Accident**, **Injury** or other medical condition and any insurer or indemnifier thereof;
2. the **Insured Person's** insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers; or
3. any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the **Accident**, **Injury** or other medical condition.

Waiting Period means the consecutive number of days an **Insured Person** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Policy**. Temporary Total Disability Benefits and Continuous Total Disability Benefits are [not] retroactive to the first day of disability. The **Waiting Period** is shown in the **Schedule**.

SECTION III - EFFECTIVE DATES AND TERMINATION DATES

Policy Effective and Termination Dates

1. Policy Effective Date. This **Policy** begins on the Policy Effective Date shown in the **Schedule** at 12:01 A.M. Standard Time at the address of the **Policyholder** where this **Policy** is delivered.

2. Policy Termination Date. This **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of:
   a. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   b. the date specified in the written notice of the **Company's** intent to terminate this **Policy**, which will be at least [thirty (30)] days after the date the **Company** sends such notice to the **Policyholder's** last known recorded address;
   c. the date specified in the written notice of the **Policyholder's** intent to terminate this **Policy**, which will be at least [thirty (30)]days after the date the **Policyholder** sends such notice to the **Company**; or
   d. at the expiration of the **Policy Period**.

If the **Company** terminates this **Policy**, any unearned premium will be returned on a pro-rata basis. If the **Policyholder** requests termination, the **Company** will return any unearned premium paid on a pro-rata basis. Termination will not affect any claim for a **Covered Loss** occurring prior to the effective date of termination.

Owner/Operator's Effective and Termination Dates

1. **Owner/Operator's** Effective Date. An **Owner/Operator's** coverage under this **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Owner/Operator** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Owner/Operator's** Termination Date: An **Owner/Operator's** coverage under this **Policy** ends on the earliest of:
   a. the date this **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   c. the date the **Owner/Operator** requests, in writing, that his or her coverage be terminated; or
   d. the date the **Owner/Operator** ceases to be an **Insured Person**.

Contract Driver's Effective and Termination Dates

1. **Contract Driver's** Effective Date. A **Contract Driver's** coverage under this **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Contract Driver** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Contract Driver's** Termination Date. A **Contract Driver's** coverage under this **Policy** ends on the earliest of:
   a. the date this **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   c. the date the **Contract Driver** requests, in writing, that his or her coverage be terminated;
   d. the date the **Contract Driver** ceases to be an **Insured Person**; or
   e. the date the **Owner/Operator**, with whom the **Contract Driver** is under contract, ceases to be an **Insured Person** and/or whose contract with the **Policyholder** terminated.

A change in an **Insured Person's** coverage under this **Policy** due to a change in the **Insured Person's** eligible class or benefit selection becomes effective on the later of: (1) the date the change in his or her eligible class or benefit selection occurs; or (2) if premium change is required, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

SECTION IV - PREMIUMS

PREMIUMS

Premiums are payable to the **Company** in the amount shown in the **Schedule**. The **Company** may change the required premiums due by giving the **Policyholder** at least [sixty (60) days] advance written notice. The **Company** may change the required premiums as a condition of any renewal of this **Policy**. The **Company** may also change the required premiums at any time when any change affecting premiums is made in this **Policy**.

The **Company** may re-underwrite and may change the terms and conditions of this **Policy** including the premium rate on the date when the number of **Insured Persons** under this **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [fifteen percent (15%)] or more. The **Policyholder** shall provide the **Company** with written notice of

such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.

PLAN AND EXPOSURE CHANGES
The **Policyholder** must notify the **Company** of any subsidiary or affiliated company that is to be covered under this **Policy**. Such notice must be sent within [thirty (30) days] of the acquisition of such subsidiary or affiliated company. If such notice is not provided, the newly acquired entity will not be considered a part of the **Policyholder** and the owner/operators or contract drivers will not be **Insured Persons** until the date that notice is provided. The **Company** has the right to decline coverage or adjust premium based on the changing exposure.

INSURED PERSON'S PREMIUM
The **Insured Person's** Premium is shown in the **Schedule** and shall be payable as follows:
1. the **Insured Person** who enrolled on or prior to the fifteenth (15th) day of the month shall pay an amount equal to the full monthly premium. No premium shall be payable for the last full or partial month of coverage; and
2. the **Insured Person** who enrolled after the fifteenth (15th) day of the month shall pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, the **Insured Person** shall pay an amount equal to the monthly premium.

INSURED PERSON'S GRACE PERIOD
A grace period of [thirty-one (31) days] will be provided for the payment of any **Insured Person's** Premium due after the first premium. The **Insured Person's** coverage will not be terminated for non-payment of premium during this grace period if the **Insured Person** pays the premium due by the last day of this grace period. The **Insured Person's** coverage will terminate if the full amount of the premium due is not paid by the last day of this grace period.

POLICY GRACE PERIOD
A grace period of [thirty-one (31)] days will be provided for the payment of any premium due after the first premium. This **Policy** will not be terminated for nonpayment of premium during this grace period if the **Policyholder** pays all premiums due by the last day of this grace period. This **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of this grace period. No Policy Grace Period will be provided if the **Company** receives notice to terminate this **Policy** prior to a premium due date.

If the **Company** expressly agrees to accept late payment of a premium without terminating this **Policy**, the **Company** does so in accordance with the Noncompliance With Policy Requirements provision in Section X of this **Policy**. In such case, the **Policyholder** will be liable to the **Company** for any unpaid premiums for the time this **Policy** is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by the **Company** in the collection of all overdue amounts.

WAIVER OF PREMIUM
During the period in which an **Insured Person** is receiving a Temporary Total Disability Benefit or Continuous Total Disability Benefit, premiums will be waived from the first premium due date on or after the benefit begins to the premium due date following the date the benefit ceases, at which time premium payments must resume. If premium payments are not resumed on that date, the **Insured Person's** coverage under this **Policy** shall terminate on that date. The **Insured Person** is responsible for reporting Waiver of Premium to the **Policyholder** or an authorized person designated by the **Policyholder** or the **Company**.

SECTION V - BENEFITS

ACCIDENTAL DEATH BENEFIT
If **Injury** to the **Insured Person** results in death within the **Commencement Period**, the **Company** will pay the **Principal Sum** to the beneficiary in accordance with the Payment of Claims provision in Section IX of this **Policy**.

SURVIVOR'S BENEFIT
If an Accidental Death Benefit is payable under this **Policy**, the **Company** will pay the **Monthly Benefit Amount**, up to the **Principal Sum**, to the **Insured Person's** surviving **Spouse**.

If the **Insured Person** is not survived by a **Spouse**, or if the **Insured Person's Spouse** dies or remarries, the **Company** will pay or continue to pay the Survivor's Benefit to the **Insured Person's** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. Payment of the **Monthly Benefit Amount** will end on the earliest of the following:

1. the date the **Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date the last **Dependent Child** dies or is no longer a **Dependent Child**; or
3. the date the **Principal Sum** has been paid.

If the **Insured Person** is not survived by a **Spouse** or any **Dependent Child(ren)**, the **Company** will not pay a Survivor's Benefit.

For this benefit, the following definition applies:

Monthly Benefit Amount means the product of the Monthly Benefit Percentage shown in the **Schedule** multiplied by the **Principal Sum**.

EXPOSURE AND DISAPPEARANCE BENEFIT

If an **Insured Person** is exposed to weather because of an **Accident**, which results in a **Covered Loss**, the **Company** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the body of the **Insured Person** has not been found within one year after the disappearance, stranding, sinking or wrecking of a power unit in which he or she was an occupant, then it will be presumed, subject to all other terms and provisions of this **Policy**, that the **Insured Person** has suffered Accidental Death within the meaning of this **Policy**. If the **Insured Person** is found and identified, the **Company** has the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to the **Insured Person** results in any one of the **Losses** specified below within the **Commencement Period**, the **Company** will pay the Percentage of the **Principal Sum** shown below:

For **Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	[100%]
Sight of Both Eyes	[100%]
One Hand and One Foot	[100%]
One Hand and the Sight of One Eye	[100%]
One Foot and the Sight of One Eye	[100%]
One Hand or One Foot	[50%]
Sight of One Eye	[50%]
Thumb and Index Finger of Same Hand	[25%]
Speech and Hearing	[50%]
Speech or Hearing	[25%]

If more than one **Loss** is sustained by an **Insured Person** as a result of the same **Accident**, only one amount, the largest, will be paid.

For this benefit, the following definition applies:

Loss, in the singular or plural, of a hand or foot means complete severance through or above the wrist or ankle joint; **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye; and **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

PARALYSIS BENEFIT

If **Injury** to the **Insured Person** results in any Type of Paralysis specified below within the **Commencement Period**, the **Company** will pay the Percentage of the **Principal Sum** shown below:

Type of Paralysis:	Percentage of the **Principal Sum**

Quadriplegia	[100%]
Paraplegia	[75%]
Hemiplegia	[50%]
Uniplegia	[25%]

If the **Insured Person** sustains more than one Type of Paralysis as a result of the same **Accident**, only the largest single amount will be considered a **Covered Loss**.

For this benefit, the following definitions apply:

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**.

Paraplegia means the complete and irreversible paralysis of both lower **Limbs**.

Hemiplegia means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body.

Uniplegia means the complete and irreversible paralysis of one **Limb**.

Limb, in the singular or plural, means entire arm or entire leg.

TEMPORARY TOTAL DISABILITY BENEFIT

If **Injury** to the **Insured Person** results in **Temporary Total Disability** within the **Commencement Period** and the **Insured Person** is under age [70] on the day the **Temporary Total Disability** begins, the **Company** will pay the following amount, after the **Waiting Period**:

1. for each week of a **Temporary Total Disability** during a **Single Period of Total Disability** the Temporary Total Disability Benefit is equal to the lesser of:
   a. the Benefit Percentage shown in the **Schedule** of the **Average Weekly Earnings**; or
   b. the **Maximum Weekly Benefit Amount**;
2. for less than a full **Benefit Week** of **Temporary Total Disability**, the Temporary Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. the date the **Insured Person** is no longer **Temporarily Totally Disabled**;
2. the date the **Insured Person** dies;
3. the date the **Maximum Benefit Period** has been reached; or
4. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to the **Company**.

For this benefit, the following definitions apply:

Average Weekly Earnings means:

1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income the **Insured Person** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income the **Insured Person** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will

use [seventy-five percent (75%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation provided he/she was not an **Owner/Operator**. If he/she was an **Owner/Operator**, then we will use 33% of the gross income.]

Insured Person must produce proof of his or her gross income and the number of weeks worked. Otherwise, the **Company** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the **Maximum Weekly Benefit Amount**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the first day of **Temporary Total Disability** after the **Waiting Period** and on the same day of each week thereafter.

Continuous Care means monthly monitoring or evaluation of the disabling condition by a **Physician**. The **Company** must receive proof of continuing **Temporary Total Disability** on a monthly basis.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following, which are considered separate periods of disability:

1. successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which the **Insured Person** is not **Temporarily Totally Disabled**; or
2. successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least six (6) months during which the **Insured Person** is not **Temporarily Totally Disabled**.

Temporary Total Disability or Temporarily Totally Disabled means disability that:

1. prevents an **Insured Person** from performing the **Material and Substantial Duties** of his or her occupation [as a commercial truck driver];
2. requires the care and treatment of a **Physician**; and
3. requires that and results in the **Insured Person** receiving **Continuous Care**.

If the **Insured Person** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured Person** shall not qualify for the Temporary Total Disability Benefit. During this period, the **Insured Person** cannot engage in any activity which results in earned income.

Material and Substantial Duties means a duty or duties which the **Insured Person** is required to perform under the terms of the written contract with the **Policyholder** or **Owner/Operator** and as described in the **Insured Person's** application.

Offsets

Subject to the **Minimum Weekly Benefit Amount**, the Temporary Total Disability Benefit shall be reduced by:

1. Social Security disability benefits excluding any amounts for which the **Insured Person's** dependents may qualify because of the **Insured Person's** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; and
4. the amount the **Insured Person** receives as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

The **Insured Person** must provide tax schedules and returns to the **Company** for the purpose of calculating this offset.

CONTINUOUS TOTAL DISABILITY BENEFIT

If **Injury** to the **Insured Person** resulting in **Temporary Total Disability** subsequently results in **Continuous Total Disability**, the **Company** will pay the following, after the **Waiting Period**:

1. for each month of a **Continuous Total Disability**, the Continuous Total Disability Benefit is four and three-tenths (4.3) times the **Weekly Benefit Amount** for **Temporary Total Disability**; or
2. for less than a full **Benefit Week** of **Continuous Total Disability**, the Continuous Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Continuous Total Disability**, but only if:
   a. Temporary Total Disability Benefits ceased solely because the **Maximum Benefit Period** has been reached, but the **Insured Person** remains disabled;
   b. the **Insured Person** is not within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration, on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached;
   c. the **Insured Person** has been granted a Social Security disability award for his or her disability (if the **Insured Person** cannot meet the credit requirement for a Social Security disability award he or she cannot qualify for the Continuous Total Disability Benefit even if he or she would otherwise qualify);
   d. the **Insured Person's** disability is reasonably expected to continue without interruption until he or she dies and is substantiated by objective medical evidence satisfactory to the **Company**;
   e. the **Injury** resulting in a **Continuous Total Disability** occurred before the **Insured Person** is within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration; [and]
   f. the **Injury** began within the **Commencement Period** [.] [; and]
   g. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**.]

The Continuous Total Disability Benefit shall cease on the earliest of the following:
1. the date the **Insured Person** is no longer **Continuously Totally Disabled**;
2. the date the **Insured Person** dies;
3. the date the **Insured Person's** Social Security disability award ceases;
4. the date the **Maximum Benefit Period** has been reached;
5. the date that the **Maximum Benefit Amount** has been paid; or
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to the **Company**.

For this benefit, the following definitions apply:
Average Weekly Earnings will be calculated as follows:
1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income the **Insured Person** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income the **Insured Person** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [seventy-five percent (75%)] of the average gross income received by the other **Insured Persons**, who were contracted within the last three (3) months prior to the covered **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation provided he/she was not an **Owner/Operator**. If he/she was an **Owner/Operator**, then we will use 33% of the gross income.]

The **Insured Person** must produce proof of his or her gross income and the number of weeks worked. Otherwise, the **Company** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the Maximum Weekly Benefit. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Total Disability or Continuously Totally Disabled means disability that:
1. prevents an **Insured Person** from performing the duties of any occupation for which he or she is qualified by reason of education, training or experience;
2. requires the care and treatment of a **Physician**; and
3. requires that, and results in, the **Insured Person** receiving **Continuous Care**.

The **Company** must receive proof of continuing **Continuous Total Disability** on a quarterly basis; provided however, that the **Company** may waive requirements 2 and 3. If the **Insured Person** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured Person** shall not qualify for **Continuous Total Disability**. During this period, the **Insured Person** cannot engage in any activity which results in earned income.

Continuous Care means at least quarterly monitoring or evaluation of the disabling condition by a **Physician**.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Continuous Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which the **Insured Person's** dependents may qualify because of the **Insured Person's** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; or
4. the amount the **Insured Person** receives as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

The **Insured Person** must provide tax schedules and returns to the **Company** for the purpose of calculating this offset.

ACCIDENT MEDICAL EXPENSE BENEFIT
If an **Insured Person** suffers an **Injury** requiring treatment by a **Physician** within the **Commencement Period**, the **Company** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Services or Charges** received or incurred due to such **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** for all **Injuries** caused by a single **Accident**, subject to any applicable **Deductible Amount**.

For this benefit, the following definitions apply:
Ambulatory Medical Center means a facility that:
1. operates under the laws of the state in which it is situated;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility.

Ambulatory Medical Center does not include a **Hospital**, **Physician's** office or clinic.

Custodial Services means any services which are not intended primarily to treat a specific injury. **Custodial Services** include, but shall not be limited to, services:
1. related to watching or protecting the **Insured Person**;
2. related to performing or assisting the **Insured Person** in performing any activities of daily living, such as:
   a. walking;
   b. grooming;
   c. bathing;
   d. dressing;
   e. getting in or out of bed;
   f. toileting;
   g. eating;
   h. preparing foods; or
   i. taking medications that can usually be self-administered; and

3. that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment means equipment of a type that is designed primarily for use by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a spa or a stationary bicycle).

Deductible Amount means the total amount of **Medically Necessary Services or Charges** that must be paid by the **Insured Person** before any Accident Medical Expense Benefit is paid under this **Policy**. The **Company** shall not be responsible for any **Medically Necessary Services or Charges** within the **Deductible Amount** as set forth in the **Schedule**.

Extended Care Facility means an institution that meets all of the following requirements:
1. operates under the laws of the state that it is situated in;
2. is approved by the United States Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a registered nurse;
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment of an **Insured Person** in his or her home as part of a treatment plan prescribed by the attending **Physician**, which is provided by a **Hospital** or agency certified to provide such services, but only if it:
1. begins within [seven (7)] days after discharge from a **Hospital**; and
2. follows a **Hospital** confinement of [five (5)] days or more.

Hospital means a facility that:
1. operates under the law of the state in which it is situated;
2. is approved by the United States Department of Health and Human Services or its successor;
3. has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
4. has 24-hour nursing service by registered nurses on duty or on call; and
5. is supervised by one or more **Physicians**.

A **Hospital** does not include:
1. a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care;
2. a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, or any ward, room, wing or other section of a hospital that is used for such purposes; or
3. any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Medically Necessary Services or Charges means one or more of the following, but only if each: (a) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (b) meets generally accepted standards of medical practice; and (c) is ordered by a **Physician** and performed under his or her care, supervision or order:
1. **Hospital** room and board charges or room and board charges in an intensive care unit; **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room); use of an **Ambulatory Medical Center**; and **Hospital** charges for in-patient treatment of a **Mental and Nervous or Depressive Condition**, as shown in the **Schedule**;
2. treatment by a **Physician** of a covered **Mental and Nervous or Depressive Condition** due to an **Injury**, as shown in the **Schedule**;
3. Ambulance service to or from a **Hospital**, as shown in the **Schedule**;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. Physical, Occupational or Work Hardening Therapies, Chiropractic Care and Acupuncture, as shown in the **Schedule**;
9. **Durable Medical Equipment** rental charges, up to the actual purchase price of such equipment;
10. the initial supply, but not any replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes;
11. medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;

12. repair or replacement of **Sound Natural Teeth** damaged or lost as a result of **Injury**, up to the Dental Benefit Maximum, if any, shown in the **Schedule**;
13. **Extended Care Facility**; or
14. **Home Health Care**.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary Services or Charges** for the care and treatment of the **Injury**, including but not limited to: (1) a non-essential private **Hospital** room; (2) television rental; and (3) **Hospital** telephone charges.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary Charge(s) means an amount(s) that:
1. does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and
2. does not include charges that would not have been made if no insurance existed[; and
3. does not exceed the cost of a generic drug, if available. The **Company** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available].

ACCIDENT MEDICAL EXPENSE BENEFIT EXCLUSIONS
In addition to the General Exclusions and Limitations in Section VIII of this **Policy**, **Medically Necessary Services or Charges** do not include expenses for or resulting from any of the following:
1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
2. dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. eye glasses or contact lenses;
4. hearing aids or hearing examinations;
5. rental of **Durable Medical Equipment** if the total rental expense exceeds the usual purchase price for similar equipment in the locality where the expense is incurred, unless authorized by the **Company**;
6. **Custodial Services**;
7. **Personal Comfort or Convenience Items**;
8. services of any government **Hospital** for which an **Insured Person** is not liable for payment;
9. any expenses covered by [Medicare, Medicaid,] a **Third Party** [or any other insurance];
10. expenses incurred which are more than the **Usual and Customary Charge**;
11. cosmetic, plastic or restorative surgery unless otherwise covered;
12. expenses which the **Insured Person** is not legally obligated to pay;
13. an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;
14. any mileage costs or lodging expenses, unless authorized by the **Company**;
15. any translation costs, unless authorized by the **Company**; or
16. **Home Health Care** services provided by an **Immediate Family Member** or **Household Member**.

SECTION VI - ADDITIONAL BENEFITS

[**RETURN OF REMAINS BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay for the transport of the body or remains (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to the **Insured Person's** county of residence. We must be contacted prior to the transportation of the body or remains and we must pre-authorize the transportation for coverage to apply. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**NON-MEDICAL REPATRIATION BENEFIT**

If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accident Medical Expense Benefit and has sufficiently recovered to travel in a regularly scheduled economy class air flight, commercial bus or train and without special medical equipment or personnel with a minimal risk to his or her health, the **Company** will pay for the return to his or her principal residence. We must be contacted prior to the transport and we must agree to the travel itinerary for coverage to apply. This benefit is subject to the prior recommendation of the attending **Physician**. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**AFTER SCHOOL CARE BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit for after school care to the individual who incurs the expense on behalf of each **Dependent Child** who is [ten (10)] years old or less, up to a maximum of the lesser of:
1. [two percent (2%)] of the applicable **Principal Sum** paid under the Accidental Death Benefit per year; or
2. [two thousand dollars ($2,000)] per year.

The after school care provider may not be an **Immediate Family Member** and written proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, to establish continued eligibility for this benefit.

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child** is under age [ten (10)] at the time of each payment. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**COMA BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** and within three hundred sixty-five (365) days of the **Accident** which caused such **Injury**, such **Injury** causes the **Insured Person** to be in a **Coma** for at least thirty-one (31) consecutive days, the **Company** will pay an additional benefit equal to [one percent (1%)] of the **Principal Sum** for such **Injury**, and such amount will be paid each month the **Insured Person** remains in a **Coma** following the initial thirty-one (31) day period. At the end of eleven (11) months of payment, if the **Insured Person** remains in a **Coma**, the **Company** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the eleven (11) months of benefit already received.

The Coma Benefit will end on the earliest of the following:
1. the date the **Insured Person** is no longer in the **Coma**; or
2. the date the **Insured Person** has received a Coma Benefit for eleven (11) months.

The **Company** may require receipt of written proof, at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Coma means a condition determined as such by the **Company's** duly licensed **Physician**.]

[**CRITICAL BURN BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss**, the **Company** will pay an additional benefit equal to the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)], but only if the **Insured Person**:
1. suffered second degree or higher burns over [twenty-five percent (25%)] of his or her body; and
2. has undergone reconstructive surgery to treat the burned areas of the body within three hundred sixty-five (365) days of the occurrence of the **Accident** that caused the **Injury**.]

[**DAY CARE BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit for day care expenses to the individual who incurs the expense for each **Dependent Child** if:
1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and

2. the **Dependent Child** is under age [thirteen (13)].

The Day Care Benefit will be equal to the lesser of:
1. the actual cost of the day care;
2. [three percent (3)%] of the **Principal Sum**; or
3. [three thousand dollars ($3,000)];

and will be paid annually for [four (4)] consecutive years if:
1. the **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. written proof acceptable to the **Company** is received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Accredited Child Care Facility means a properly licensed childcare facility that operates pursuant to state and local laws and has a Tax Identification Number issued by the Internal Revenue Service. **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**FELONIOUS ASSAULT BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** for an **Occupational Injury** payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Paralysis Benefit as a result of a **Felonious Assault** by someone other than himself or herself, an **Insured Person** or an **Immediate Family Member** or **Household Member**, the **Company** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum**, but only if:
1. the **Felonious Assault** occurs while the **Insured Person** is under **Dispatch**; and
2. the crime directly involves the **Policyholder's** or the **Insured Person's** funds or assets.

For this benefit, the following definition applies:

Felonious Assault means the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]

[**HIGHER EDUCATION BENEFIT**
If the **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay a benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**, but only if on the date of the **Accident**, the **Dependent Child**:
1. is enrolled as a full-time student in an accredited college, university or trade school; or
2. is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The Higher Education Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit for all **Dependent Child(ren)** combined is [twenty thousand dollars ($20,000)].]]

[**HIJACKING BENEFIT**
The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions and Limitations of this **Policy** is modified and an **Injury** directly resulting from a **Hijacking** or any attempt at any **Hijacking** is covered under this **Policy**.

This benefit will continue beyond the actual **Hijacking** while the **Insured Person** is:
1. subject to the control of the person(s) making the **Hijacking**; and

2. traveling directly to the **Insured Person's** home or original destination.

For this benefit, the following definition applies:

Hijacking means the unlawful seizure or wrongful exercise of control of a power unit occupied by the **Insured Person**, while the **Insured Person** is getting into, riding in, or getting out of and while under **Dispatch**.]

[**VEHICLE MODIFICATION BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Dismemberment Benefit or Paralysis Benefit, the **Company** will pay an additional benefit equal to the actual cost for modifications to his or her motor vehicle that are necessary to make it accessible or drivable, but only if such **Injury** requires the **Insured Person** to use a wheelchair. Benefits are not payable unless:
1. the modifications are made by a person(s) experienced in such modifications and are recommended by an organization recognized for providing support and assistance to wheelchair users; and
2. proof sufficient to the **Company** is received by the **Company**, establishing eligibility for this benefit.

The maximum amount payable under this benefit will be the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)].]

[**SEAT BELT BENEFIT**
If an **Insured Person** suffers an **Injury** directly resulting from an automobile **Accident** resulting in a **Covered Loss** payable under the Accidental Death Benefit or Survivor's Benefit, the **Company** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum** up to a maximum of [ten thousand dollars ($10,000)], but only if the **Insured Person** was:
1. operating or riding as a passenger in a motorized vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Accident**.

The **Insured Person's** actual use of the seat belt or lap and shoulder restraints must be verified in the official law enforcement report of the **Accident**, through certification by the investigating officers; or by other reasonable proof, acceptable to the **Company**.]

[**SPOUSE RETRAINING BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit to his or her **Spouse** for the actual cost of any state licensed professional or trade-training program in which the **Spouse** enrolls and completes, but only if the purpose of the program is to obtain an independent source of support and maintenance and the actual cost is incurred within [thirty (30)] months from the death of the **Insured Person**.

The Spouse Retraining Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Spouse** continues his or her training. Before this benefit is paid each year, proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit is [twenty thousand dollars ($20,000)].]

SECTION VII - LIMITS OF LIABILITY

The **Combined Single Limit of Liability** shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Loss** with respect to an **Insured Person** arising out of **Injury** sustained by such individual as the result of any one **Accident** or Occurrence. The term Occurrence means a single event or related events or originating cause occurring within a 24-hour period.

The **Aggregate Limit of Liability** shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

If either the **Combined Single Limit of Liability** or the **Aggregate Limit of Liability** is not enough to pay all **Covered Loss**, the **Company** will pay reduced benefit amounts based upon the proportion that the **Covered Loss** bears to each benefit or expected total benefits that would otherwise be payable. If the total benefits are unknown, the **Company** will determine the total expected benefits for each **Insured Person**.

Limitation on Multiple **Covered Loss**. If an **Insured Person** suffers more than one **Covered Loss** under one benefit as a result of the same **Accident**, the **Company** will pay only up to the largest **Covered Loss** amount.

Limitation on Multiple Benefits. If an **Insured Person** can recover benefits under two or more of the Accidental Death Benefit, Accidental Dismemberment Benefit, [Coma Benefit] or the Accidental Paralysis Benefit as a result of the same **Accident**, the **Company** will pay only up to the highest applicable **Principal Sum**.

SECTION VIII - GENERAL EXCLUSIONS AND LIMITATIONS

This **Policy** does not cover any losses contributed to or caused by, in whole or in part, by any of the following:

1. [suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** or any **Injury** resulting from a provoked attack;]
2. [sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning [or routine and temporary non chronic sickness or illness such as a cold, cough, headache or nausea];]
3. [a **Pre-existing Condition**, until the **Insured Person** has been continuously covered under this **Policy** for [twelve (12)] consecutive months;]
4. [**Occupational Cumulative Trauma** or **Cumulative Trauma and Repetitive Conditions**, unless shown in the **Schedule**;]
5. [**Occupational Disease**, unless shown in the **Schedule**;]
6. [performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;]
7. [declared or undeclared war, or any act of declared or undeclared war;]
8. [full-time active duty in the armed forces of any country or international authority;]
9. [any **Injury** for which the **Insured Person** is entitled to benefits pursuant to any workers' compensation law or other similar legislation;]
10. [any loss insured by employers' liability insurance;]
11. [the **Insured Person** being intoxicated:
    a. the **Insured Person** is conclusively deemed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the **Injury** occurs; and
    b. an autopsy report from a licensed medical examiner, law enforcement officer reports or similar items will be considered proof of the **Insured Person's** intoxication;]
12. [the **Insured Person** being under the influence of any illegal substance, drug, narcotic, or hallucinogen, unless such drug, narcotic, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage;]
13. [the **Insured Person's** commission of or attempt to commit a felony or a Class A misdemeanor;]
14. [travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the **Insured Person** is:
    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or the **Insured Person**;]
15. [skydiving, parasailing, hang-gliding, bungee-jumping [or any similar activity];] [or]
16. [charges incurred for treatment of a covered **Injury**, when the **Insured Person** obtains compensation for the covered **Injury** from a **Third Party**].

[INCARCERATION LIMITATION

Benefits provided to an **Insured Person** will cease while the **Insured Person** is incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when the **Insured Person** is released from such facility.]

SECTION IX - CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be received by the **Company** within twenty (20) days after an **Insured Person's** loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the **Company** at Zurich American Insurance Company Group Accident Claims Division, [P.O. Box 968041 Schaumburg, IL 60196] with information sufficient to identify the **Insured Person**, is deemed notice to the **Company**.

CLAIM FORMS
The **Company** will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within thirty (30) days after the giving of notice, the claimant will be deemed to have met the Proof of Loss requirements upon submitting, within the time fixed in this **Policy** for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the **Insured Person's** name, the **Policyholder's** name and the Policy Number.

PROOF OF LOSS
Written Proof of Loss acceptable to the **Company** must be received by the **Company** within ninety (90) days after the date of the loss. If the loss is one for which this **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proof acceptable to the **Company** must be received by the **Company**, at such intervals as the **Company** may reasonably require, establishing continued eligibility for the benefit. Failure to furnish such proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time such proof is otherwise required. The **Company** has a right to investigate any documents that the **Insured Person** shall make available to the **Company** upon request.

PAYMENT OF CLAIMS
Upon receipt of written proof of death, payment for loss of life of an **Insured Person** will be made to the **Insured Person's** beneficiary or, if there is no beneficiary designated, the **Insured Person's** survivors in the following order:
1. the **Insured Person's Spouse**;
2. the **Insured Person's** child(ren);
3. the **Insured Person's** parents;
4. the **Insured Person's** brothers and sisters;
5. the **Insured Person's** estate.

Upon receipt of written Proof of Loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the **Insured Person**. If the **Insured Person** dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary or, if there is no beneficiary designated, the **Insured Person's** survivors in the order as listed above.

BENEFICIARY DISIGNATION AND CHANGE
The **Insured Person's** designated beneficiary(ies) is (are) the person(s) so named by the **Insured Person** as shown on the **Policyholder's** records kept on this **Policy**.

A legally competent **Insured Person** over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the **Policyholder** with a written request for change. When the request is received by the **Policyholder**, whether the **Insured Person** is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the **Company** on account of any payment which is made prior to receipt of the request.

Except for the Survivor's Benefit, if there is no designated beneficiary or no designated beneficiary is living after the **Insured Person's** death, payment will be made to the **Insured Person's** estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding one thousand dollars ($1,000) may be made, at the **Company's** option, to any relative by blood or connection by marriage of the payee, who, in the **Company's** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

The **Company** shall pay benefits directly to any **Hospital** or person rendering covered services, unless the **Insured Person** requests otherwise in writing and provides proof that payment was made directly to such **Hospital** or person. Such request must be made no later than the time Proof of Loss is filed. Any payment the **Company** makes in good faith fully discharges the **Company's** liability to the extent of the payment made.

TIME OF PAYMENT OF CLAIM
Benefits payable under this **Policy** for any loss other than loss for which this **Policy** provides any periodic payment will be paid within thirty (30) days upon the **Company's** receipt of written Proof of Loss. Benefits payable periodically under this **Policy** will be paid at four (4) week intervals during the continuance of the period for which the **Company** is liable, subject to the **Company's** receipt of written Proof of Loss, and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

REHABILITATION
The **Company** will consider paying for a rehabilitation program for the **Insured Person** based on an **Occupational Assessment** provided he or she is receiving benefits under either the **Temporary Total Disability Benefit** or the **Continuous Total Disability Benefit**. The rehabilitation program must be mutually agreed upon by the **Insured Person** and the **Company**. The extent of the **Company's** participation will be determined solely by the **Company**. Any benefits payable will continue during the **Insured Person's** rehabilitation unless otherwise agreed to by the **Company**.

SUNSET
In no event shall benefits under this **Policy** be payable unless written Proof of Loss is received by the **Company** within [three (3) years] from the date of the **Accident**.

[**ARBITRATION**
Any contest to a claim denial under this **Policy** shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration shall occur at the offices of the American Arbitration Association nearest to the **Insured Person** or the person claiming to be the beneficiary. The arbitrator(s) shall not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Insured Person** or the person claiming to be the beneficiary is a citizen of a state where the law does not allow binding arbitration in an insurance policy but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. [Non-binding arbitration is required and no legal action may be brought by the **Insured Person**, the beneficiary, or the **Company** until thirty (30) days after the arbitrator(s) issues a non-binding award.] This provision bars the institution of any individual or class action lawsuit brought by the **Insured Person** or the beneficiary.]

SECTION X - GENERAL PROVISIONS

ENTIRE CONTRACT
This **Policy**, together with any riders, endorsements, amendments, applications, enrollment forms and attached papers, if any, make up the entire contract between the **Policyholder** and the **Company**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by an **Insured Person** will be used in any contest unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or personal representative.

No changes in this **Policy** will be valid until approved by an officer of the **Company**. The approval must be noted on or attached to this **Policy**. No agent may change this **Policy** or waive any of its provisions.

CERTIFICATE OF INSURANCE
The **Company** will provide the **Policyholder** with a Certificate of Insurance, in either paper or electronic format, for delivery to each **Insured Person**, where required by state law. Such Certificate of Insurance will contain a summary of terms that affect benefits.

INCONTESTABILITY
The validity of this **Policy** will not be contested after it has been in force for two year(s) from the Policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

POLICYHOLDER RECORDS
The **Policyholder** will keep a record of the coverage, premium, beneficiary designation and other pertinent administrative information for each **Insured Person** which, if acceptable to the **Company**, shall be deemed to be a part of this **Policy**. The **Company** may examine these records at any reasonable time while the **Policy** is in force and for six (6) years after the termination of this **Policy**. The **Policyholder** will report to the **Company** within a reasonable time all changes in information regarding an **Insured Person**. [The **Policyholder** shall indemnify the **Company** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the administration described herein.]

PHYSICAL EXAMINATION AND AUTOPSY
The **Company** has the right, at its own expense, to examine the **Insured Person** whose **Injury** is the basis of a claim, when and as often as it may be reasonably required while a claim is pending. The **Company** may also require an autopsy where it is not prohibited by law.

LEGAL ACTIONS
In those states where binding arbitration is not allowed, no legal action for a claim can be brought against the **Company** until sixty (60) days after receipt of written Proof of Loss. In those states where binding arbitration is not allowed, no legal action for a claim can be brought against the **Company** more than three (3) years (six (6) years in South Carolina and Wisconsin, five (5) years in Kansas, Florida and Tennessee) after the time for giving written Proof of Loss. In those states where binding arbitration is allowed, binding arbitration shall supersede this provision.

NONCOMPLIANCE WITH POLICY REQUIREMENTS
Any express waiver by the **Company** of any requirements of this **Policy** will not constitute a continuing waiver of such requirements. Any failure by the **Company** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

CONFORMITY WITH STATE STATUTES
Any provision of this **Policy** that, on its effective date, is in conflict with the statutes of the state in which the **Policy** was delivered, is hereby amended to conform to the minimum requirements of such laws.

CLERICAL ERROR
Clerical error, whether by the **Policyholder**, the Producer or the **Company**, in keeping records pertaining to this **Policy**, will not:
1. invalidate coverage otherwise validly in force; or
2. continue coverage otherwise validly terminated.

DATA REQUIRED
The **Policyholder** must maintain adequate records acceptable to the **Company** and provide any information required by the **Company** relating to this insurance.

AUDIT
The **Company** will have the right to inspect and audit, at any reasonable time, all records and procedures of the **Policyholder** that may have a bearing on this insurance.

ASSIGNMENT
This **Policy** is non-assignable.

SUBROGATION
The **Company** has the right to recover all payments including future payments, which the **Company** has made to the **Insured Person** or on behalf of the **Insured Person's** covered dependents, heirs, guardians or executors or will be obligated to pay in the future to the **Insured Person**, from any **Third Party**. If the **Insured Person** recovers from any **Third Party**, the **Company** will be reimbursed first from such recovery to the extent of the **Company's** payments to the **Insured Person**. The **Insured Person** agrees to assist the **Company** in preserving its rights against any **Third Party**, including but not limited to, signing subrogation forms supplied by the **Company**.

[**MADE WHOLE DOCTRINE**
The **Company** has the right to recover any and all first monies paid (or payable) to or on behalf of the **Insured Person** and to any and all claims of or on behalf of the **Insured Person**, to the extent of benefits paid by this **Policy**, and regardless of whether or not the beneficiary has been made whole. Made whole shall include first dollar recovery with no offset for attorneys' fees.]

RIGHT TO RECOVER OVERPAYMENTS
In addition to any rights of recovery, reimbursement or subrogation provided to the **Company** herein, when payments have been made by the **Company** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this **Policy**, the **Company** shall have the right to recover such excess payment, from any person to whom such payments were made. The **Company** maintains the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under the **Policy** to the extent of the overpayment.

CONDITIONAL CLAIM PAYMENT
If an **Insured Person** suffers a **Covered Loss** as the result of an **Injury** for which a **Third Party** may be liable, the **Company** will pay the amount of benefits otherwise payable under this **Policy**. However, if the **Insured Person** receives payment from the **Third Party**, the **Insured Person** agrees to refund to the **Company** the lesser of:
1. the amount actually paid by the **Company** for such **Covered Loss**; or
2. an amount equal to the sum actually received from the **Third Party** for such **Covered Loss**.

If the **Insured Person** does not receive payment from the **Third Party** for such **Covered Loss**, the **Company** reserves the right to subrogate under the Subrogation clause of this **Policy**.

At the time such **Third Party** liability is determined and satisfied, this amount shall be paid whether determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.

[**OFFSET DEBT**
The **Company** will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from the **Policyholder** to the **Company** against any balance or balances, whether on account of losses or otherwise, due from the **Company** to the **Policyholder**.]

[**CLAIMS FOR WORKERS' COMPENSATION AND OTHER INSURANCE**
No benefits shall be payable under this **Policy** for any loss for which the **Insured Person** claims or files for any workers' compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, the **Company** shall determine its liability under this **Policy**. The **Company** reserves the right to recover, from the **Insured Person**, any benefits paid under this **Policy** that are subsequently paid for under any workers' compensation, employers' liability, occupational disease or similar law or any other insurance.]

[Workers' Compensation Indemnification. If an **Insured Person** is determined by a court of law or the appropriate state regulatory authority to be covered under workers' compensation insurance for a **Covered Loss**, any benefits for which the **Insured Person** is eligible under this **Policy**, are payable to the person who was determined to be the **Insured Person's** employer or such person's designee or assignee.]

SECTION XI – IMPORTANT NOTICE

The Insured Person may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if they need assistance in resolving any complaints. Or, the Insured Person may write to Zurich American Insurance Company at their administrative offices at [XXXXXX].

Should the Insured Person wish to contact the Arkansas Insurance Department for assistance, they may do so by calling [1-800-282-9134]. Or, the Insured Person may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

[Truckers] [Occupational] Accident Insurance Certificate

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

This is a summary of the accident insurance **We** provide on behalf of the **Policyholder** to **You** if **You** are within a class of eligible persons described in the **Schedule** and if the required premiums are paid when due.

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]

THE INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE ONLY. THE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

THIS IS A SUMMARY OF COVERAGE ONLY WHICH SUMMARIZES AND EXPLAINS THE PARTS OF THE POLICY WHICH APPLY TO YOU.

FOR ALL TERMS AND CONDITIONS OF COVERAGE, PLEASE REVIEW THE POLICY ISSUED TO THE POLICYHOLDER AND ON FILE WITH THEM AT THEIR PLACE OF BUSINESS. YOU CAN OBTAIN A COPY OF THE POLICY FROM THE POLICYHOLDER.

THIS CERTIFICATE IS NOT AN INSURANCE POLICY. IN THE EVENT OF A CONFLICT OF PROVISIONS BETWEEN THE POLICY AND THIS CERTIFICATE, THE PROVISIONS OF THE POLICY WILL GOVERN.

IMPORTANT NOTICE
THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.

PLEASE READ THIS CERTIFICATE CAREFULLY

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THIS CERTIFICATE IS NOT WORKERS' COMPENSATION AND DOES NOT REQUIRE PRE-AUTHORIZATION OF A PHYSICIAN FOR COVERED SERVICES OR TREATMENT. YOU MAY CONSULT US AT [1-888-889-5330] TO DETERMINE IF A SERVICE OR TREATMENT IS COVERED. WE CAN PROVIDE YOU WITH THE NAME AND ADDRESS OF A PHYSICIAN WHO IS A PREFERRED PROVIDER.

YOU CANNOT BE COVERED BY ANY OTHER OCCUPATIONAL ACCIDENT POLICY ISSUED BY **US**. IF **YOU** PAY PREMIUM BUT ARE NOT ELIGIBLE FOR COVERAGE OR DO NOT QUALIFY FOR BENEFITS UNDER THE **POLICY**, **WE** WILL REFUND ANY UNEARNED PREMIUM PAID IN ERROR.

SECTION I - SCHEDULE

Policy Effective Date: [01/01/09]
[**Policy Period**: [01/01/09] to [01/01/10]]
[Policy] Premium Due Date: [01/01/09]
Policy Number: [XXXXXX-XX]

Your Premium: [$0.00]

Policyholder: [Name of Trucking Company]
[Address]
[City, State, Zip]

Eligible Persons

You are eligible to become an **Insured Person** under the **Policy** if **You** meet the following criteria:

CLASS I: **Actively at Work Owner/Operator** who has enrolled for coverage under the **Policy**.
CLASS II: **Actively at Work Contract Driver** who has enrolled for coverage under the **Policy**.

Benefits Summary

	Occupational Injuries	**Non-Occupational Injuries**
☐ Accidental Death Benefit:		
Principal Sum*	[$50,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Survivor's Benefit:		
Principal Sum*	[$175,000.00]	[$7,500.00]
Monthly Benefit Percentage of **Principal Sum**	[1.0%]	[1.0%]
Monthly Benefit Amount	[$1,750.00]	[$1,750.00]
☐ Accidental Dismemberment Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accidental Paralysis Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accident Medical Expense Benefit:		
Commencement Period	[90 days]	[90 days]
Deductible Amount	[$0.00]	[$0.00]
Maximum Benefit Amount	[$1,000,000.00]	[$5,000.00]
Maximum Benefit Period	[104 weeks]	[52 weeks]
Dental Benefit Maximum	[$2,500.00]	[$1,000.00]
Lifetime **Maximum Benefit Amount**	[$1,000,000.00]	[$10,000.00]
Physical, Occupational, or Work Hardening Therapies	To a maximum-combined [36] visits	[N/A]
Ambulance for Medically Necessary Services	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**

	Occupational Injuries	**Non-Occupational Injuries**
Acupuncture Care and Chiropractic Care	[$1,000.00] per **Injury**	N/A
[Hernia Coverage]	[$10,000.00]	N/A
[Hemorrhoid Coverage]	[$10,000.00]	N/A
Mental and Nervous or Depressive Condition	1 visit per day to a maximum of [$25.00] per visit and [20] visits per **Accident**	N/A
[**Occupational Cumulative Trauma**]	[$20,000.00]	N/A
[**Occupational Disease**]	[$20,000.00]	N/A

☐ Temporary Total Disability Benefit:

Commencement Period	[90 days]	[90 days]
Waiting Period	[7 days]	[7 days]
Benefit Percentage	[70.0%]	[70.0%]
Minimum Weekly Benefit Amount	[$125.00]	[$125.00]
Maximum Weekly Benefit Amount	[$500.00]	[$500.00]
Maximum Benefit Period**	[104 weeks]	[12 weeks]
[**Maximum Benefit Period** for Hernia]	[90 days]	N/A
[**Maximum Benefit Period** for Hemorrhoid]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Disease**]	[90 days]	N/A

☐ Continuous Total Disability Benefit: ***

Waiting Period	[equals **Maximum Benefit Period** for **Temporary Total Disability**]	N/A
Benefit Percentage	[70.0%]	N/A
Minimum Weekly Benefit Amount	[$50.00]	N/A
Maximum Weekly Benefit Amount	[$500.00]	N/A
Maximum Benefit Amount	[$300,000.00]	N/A
Maximum Benefit Period	Up to age 70, but not beyond full Social Security retirement age	N/A

☐ Additional Benefits:

[Return of Remains Benefit]	[Refer to SECTION VI]	N/A
[Non-Medical Repatriation Benefit]	[Refer to SECTION VI]	N/A
[After School Care Benefit]	[Refer to SECTION VI]	N/A
[Coma Benefit]	[Refer to SECTION VI]	N/A
[Critical Burn Benefit]	[Refer to SECTION VI]	N/A
[Day Care Benefit]	[Refer to SECTION VI]	N/A
[Felonious Assault Benefit]	[Refer to SECTION VI]	N/A
[Higher Education Benefit]	[Refer to SECTION VI]	N/A
[Hijacking Benefit]	[Refer to SECTION VI]	N/A
[Vehicle Modification Benefit]	[Refer to SECTION VI]	N/A
[Seat Belt Benefit]	[Refer to SECTION VI]	N/A
[Spouse Retraining Benefit]	[Refer to SECTION VI]	N/A

Limits of Liability:

Combined Single Limit of Liability	[$1,000,000.00]	[$10,000.00]
Aggregate Limit of Liability	[$2,000,000.00]	[$15,000.00]
Sub Limits of Liability:		
[**Combined Single Limit of Liability** for:		
[Hernia]	[$20,000.00]	N/A

	Occupational Injuries	Non-Occupational Injuries
[Hemorrhoid]	[$20,000.00]	N/A
[**Occupational Disease**]	[$50,000.00]	N/A
[**Occupational Cumulative Trauma**]	[$50,000.00]	N/A

* Starting at age [65], the **Principal Sum** shall be based on the following schedule:

Age at Date of Loss	Percent of **Principal Sum**
[65]	[80%]
[66]	[60%]
[67]	[40%]
[68]	[20%]
[69]	[15%]
[70 and over]	[10%]

** If **You** suffer an **Injury** at or after age [70], the **Maximum Benefit Period** shall be [one (1) year].

*** If **You** sustain an **Injury** within six months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration, **You** do not qualify for the Continuous Total Disability Benefit.

SECTION II - GENERAL DEFINITIONS

Accident means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while coverage is in effect under the **Policy**.

Actively at Work means under **Dispatch** for at least [30] hours each week.

Aggregate Limit of Liability shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

Assignment means the **Policyholder** has offered and **You** have accepted a shipment of freight as recorded in the books and records of the **Policyholder** in the ordinary course of business.

Certificate means this [Truckers] [Occupational] Accident Insurance Certificate.

Company means Zurich American Insurance Company.

Co-Owner means a person who has partial ownership of a vehicle operating as an **Owner/Operator**.

Combined Single Limit of Liability means, with respect to **You**, the maximum amount that **We** will pay for all **Covered Loss** under the **Policy** for or in connection with **Injury** to **You** resulting from any one **Accident**. When the **Combined Single Limit of Liability** has been reached, no further benefits shall be payable under the **Policy**, with respect to **You**, for or in connection with **Injury** sustained as the result of that one **Accident**.

Commencement Period means the period between the date of the **Accident** that caused the **Injury** and the date on which the **Covered Loss** must occur for benefits to be payable under the Accidental Death Benefit, the Accidental Dismemberment Benefit, Accidental Paralysis Benefit, Accident Medical Expense Benefit and/or the Temporary Total Disability Benefit.

Contract Driver means an individual who:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [is authorized by an **Owner/Operator** to operate a power unit owned or leased by an **Owner/Operator** and must neither own nor lease the power unit;]
3. [is compensated on a basis other than time expended in the performance of work;]
4. [is responsible for determining the route and time for **Assignment**;]
5. [has the principal duty to operate the power unit;]

6. [is classified as an independent contractor by the **Policyholder** and the **Owner/Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance, or for any other purpose, [unless workers' compensation coverage is not mandatory for such person as an employee of either the **Policyholder** or **Owner/Operator**];] and
7. [receives for federal income tax reporting purposes a 1099 and not a W-2].

Covered Loss, in the singular or plural, means one or more of the losses or expenses identified in Sections V and VI of this **Certificate** that are not specifically excluded herein.

Cumulative Trauma or Repetitive Conditions means **Non-Occupational** conditions that impair the normal physiological function of the body over an extended period, but do not arise as the result of a single **Accident**.

Dependent Child(ren) means **Your** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption, who are:
1. under age 19 or under age 23 if he or she [:] [(a)] is enrolled in accredited institution of higher learning on a full-time basis, [and (b) relies on **You** for more than 50% of his or her support and is taken as a dependent on **Your** Federal Income Tax Return]; or
2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on **You** for support and maintenance as defined herein.

We may require proof of the **Dependent Child(ren)'s** incapacity and dependency before the **Dependent Child(ren)** reached the age limit specified above. **We** may request that satisfactory proof of the **Dependent Child(ren)'s** continued incapacity and dependency be submitted to **Us** on an annual basis.

Deleted: within 60 days

Dispatch means the time during which **You** are on **Assignment** or **You** are performing tasks prior to or after an **Assignment** to prepare the contracted vehicle for a current or future **Assignment**. **Dispatch** must be authorized by the **Policyholder** and includes the following:
1. in route to pick up a load;
2. picking up a load;
3. in route to delivering a load;
4. unloading a load;
5. the waiting time for a load;
6. returning from delivering a load;
7. in route to, returning from or performing a pre-trip inspection as required by a recognized governmental agency and/or the contracted motor carrier;
8. [while performing vehicle maintenance or repairs on the contracted vehicle during any of the foregoing times; and]
9. [while performing verifiable vehicle maintenance or repairs on the contracted vehicle; and]
10. performing activities to comply with federal or state laws or to satisfy contracted motor carrier requirements.

Eligible Person(s) means a Class I or Class II individual described in the **Schedule**.

Household Member means a person who maintains residence at the same address as **You** and is not an **Immediate Family Member**.

Immediate Family Member means **Your Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, stepparent, brother, sister, stepbrother, stepsister, child, child who has been legally adopted, or stepchild.

Injury, in the singular or plural, means bodily injury caused by an **Accident**, which occurs while **You** are covered under the **Policy** and the **Injury** must result directly and independently of all other causes, in a **Covered Loss**. All **Injuries** sustained by **You** in any one **Accident** shall be considered a single **Injury**.

Insured Person(s) means an **Owner/Operator** or **Contract Driver**:
1. who is enrolled for coverage under the **Policy**;
2. who has paid the required premium when due; and
3. whose coverage is in effect under the **Policy**.

Maximum Benefit Amount means the maximum amount that **We** will pay under the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Amount** is shown in the **Schedule**.

Maximum Benefit Period means the maximum period that **We** will pay benefits, after the **Waiting Period**, under the Temporary Total Disability Benefit, the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Period** is shown in the **Schedule**.

Maximum Weekly Benefit Amount means the maximum amount that **We** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Maximum Weekly Benefit Amount** is shown in the **Schedule**.

Mental and Nervous or Depressive Condition means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.

Minimum Weekly Benefit Amount means the minimum amount that **We** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Minimum Weekly Benefit Amount** is shown in the **Schedule**.

Non-Occupational means benefits payable for an **Injury** due to an **Accident** sustained by **You** while not under **Dispatch**.

Occupational means, with respect to an activity, **Accident**, incident, circumstance or condition involving **You**, that the activity, **Accident**, incident, circumstance or condition occurs or arises out of or in the course of **You** performing services within the course and scope of contractual obligations for the **Policyholder**, and while under **Dispatch**. **Occupational** does not encompass any period during the course of everyday travel to and from work, other than as allowed under **Dispatch**, or while on vacation.

Occupational Assessment means a test of vocational capabilities, including review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), and evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

Occupational Cumulative Trauma means bodily injury that impairs the normal physiological function of the body caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time and does not arise as the result of a single **Accident**, when:
1. such condition is diagnosed by a **Physician**;
2. **Your** last day of last performance of the activities causing the bodily injury occurred while **Your** coverage is in effect; and
3. such bodily injury resulted directly, and independently of all other causes, in a **Covered Loss**.

Occupational Disease means a sickness that results in disability or death, and is caused by exposure to environmental or physical hazards during the course of **Your Occupational** activities, when:
1. such sickness is diagnosed by a **Physician** and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards;
2. exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which **You** perform **Occupational** activities;
3. **Your** last day of last exposure to the environmental or physical hazards causing such sickness occurs while **Your** coverage is in effect; and
4. such exposure results directly and independently of all other causes in a **Covered Loss**.

Owner/Operator means an individual who leases to or from the **Policyholder** and:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [owns or leases a power unit;]
3. [is responsible for the maintenance and operating costs of the power unit, including, but not limited to fuel, repairs and supplies;]
4. [is compensated on a basis other than time expended in the performance of work;]
5. [is responsible for determining the route and time for **Assignment**;]
6. [has the right to select or reject the load;]
7. [has a written contract or **Assignment** from the **Policyholder** and is classified as an independent contractor by the **Policyholder** and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;] and

8. [receives for federal income tax reporting purposes a 1099 not a W-2].

Physician means a qualified medical doctor acting within the scope of his or her license who is not:
1. **You**;
2. an **Immediate Family Member**;
3. a **Household Member**; or
4. a practitioner retained by the **Policyholder**.

Policy means the [Truckers] [Occupational] Accident Insurance Policy issued to the **Policyholder**.

Policyholder means the entity named as **Policyholder** in the **Schedule**.

Policy Period means the period shown in the **Schedule**, subject to prior termination pursuant to Section III of the **Policy**.

Pre-Existing Condition means a condition for which **You** have sought or received medical advice or treatment at any time during the twelve months immediately preceding **Your** effective date of coverage under the **Policy**.

Principal Sum means the maximum amount that **We** will pay under the Accidental Death Benefit, the Survivor's Benefit, the Accidental Dismemberment Benefit or the Accidental Paralysis Benefit. The applicable **Principal Sum** is shown in the **Schedule** and is subject to the **Combined Single Limit of Liability** and the **Aggregate Limit of Liability**.

Schedule means SECTION I of the **Policy** and this **Certificate**.

Spouse means **Your** legal spouse.

Third Party in the singular or plural means, but is not limited to, the following:
1. the party that caused the **Accident**, **Injury** or other medical condition and any insurer or indemnifier thereof;
2. **Your** insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers; or
3. any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the **Accident**, **Injury** or other medical condition.

Waiting Period means the consecutive number of days **You** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Policy**. Temporary Total Disability Benefits and Continuous Total Disability Benefits are [not] retroactive to the first day of disability. The **Waiting Period** is shown in the **Schedule**.

We, **Us**, and **Our** means Zurich American Insurance Company.

You, **Your**, and **Yourself** means the **Insured Person** to whom a **Certificate** is issued.

SECTION III - EFFECTIVE DATES AND TERMINATION DATES

Policy Effective and Termination Dates

1. Policy Effective Date. The **Policy** begins on the Policy Effective Date shown in the **Schedule** at 12:01 A.M. Standard Time at the address of the **Policyholder** where the **Policy** is delivered.

2. Policy Termination Date. The **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of:
   a. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   b. the date specified in the written notice of **Our** intent to terminate the **Policy**, which will be at least [thirty (30)] days after the date **We** send such notice to the **Policyholder's** last known recorded address;
   c. the date specified in the written notice of the **Policyholder's** intent to terminate the **Policy**, which will be at least [thirty (30)]days after the date the **Policyholder** sends such notice to **Us**; or
   d. at the expiration of the **Policy Period**.

   If **We** terminate the **Policy**, any unearned premium will be returned on a pro-rata basis. If the **Policyholder** requests termination, **We** will return any unearned premium paid on a pro-rata basis. Termination will not affect any claim for a **Covered Loss** occurring prior to the effective date of termination.

Owner/Operator's Effective and Termination Dates

1. **Owner/Operator's** Effective Date. An **Owner/Operator's** coverage under the **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Owner/Operator** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Owner/Operator's** Termination Date: An **Owner/Operator's** coverage under the **Policy** ends on the earliest of:
   a. the date the **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   c. the date the **Owner/Operator** requests, in writing, that his or her coverage be terminated; or
   d. the date the **Owner/Operator** ceases to be an **Insured Person**.

Contract Driver's Effective and Termination Dates

1. **Contract Driver's** Effective Date. A **Contract Driver's** coverage under the **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Contract Driver** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Contract Driver's** Termination Date. A **Contract Driver's** coverage under the **Policy** ends on the earliest of:
   a. the date the **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   c. the date the **Contract Driver** requests, in writing, that his or her coverage be terminated;
   d. the date the **Contract Driver** ceases to be an **Insured Person**; or
   e. the date the **Owner/Operator**, with whom the **Contract Driver** is under contract, ceases to be an **Insured Person** and/or whose contract with the **Policyholder** terminated.

A change in **Your** coverage under the **Policy** due to a change in **Your** eligible class or benefit selection becomes effective on the later of: (1) the date the change in **Your** eligible class or benefit selection occurs; or (2) if premium change is required, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

SECTION IV - PREMIUMS

PREMIUMS

Premiums are payable to **Us** in the amount shown in the **Schedule**. **We** may change the required premiums due by giving the **Policyholder** at least [sixty (60) days] advance written notice. **We** may change the required premiums as a condition of any renewal of the **Policy**. **We** may also change the required premiums at any time when any change affecting premiums is made in the **Policy**.

We may re-underwrite and may change the terms and conditions of the **Policy** including the premium rate on the date when the number of **Insured Persons** under the **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [fifteen percent (15%)] or more. The **Policyholder** shall provide **Us** with written notice of such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.

PLAN AND EXPOSURE CHANGES

The **Policyholder** must notify **Us** of any subsidiary or affiliated company that is to be covered under the **Policy**. Such notice must be sent within [thirty (30) days] of the acquisition of such subsidiary or affiliated company. If such notice is not

provided, the newly acquired entity will not be considered a part of the **Policyholder** and the owner/operators or contract drivers will not be **Insured Persons** until the date that notice is provided. **We** have the right to decline coverage or adjust premium based on the changing exposure.

YOUR PREMIUM
Your Premium is shown in the **Schedule** and shall be payable as follows:
1. if **You** enroll on or prior to the fifteenth (15th) day of the month, **You** shall pay an amount equal to the full monthly premium. No premium shall be payable for the last full or partial month of coverage; and
2. if **You** enroll after the fifteenth (15th) day of the month, **You** shall pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, **You** shall pay an amount equal to the monthly premium.

YOUR GRACE PERIOD
A grace period of [thirty-one (31) days] will be provided for the payment of **Your** Premium due after the first premium. **Your** coverage will not be terminated for non-payment of premium during this grace period if **You** pay the premium due by the last day of this grace period. **Your** coverage will terminate if the full amount of the premium due is not paid by the last day of this grace period.

POLICY GRACE PERIOD
A grace period of [thirty-one (31)] days will be provided for the payment of any premium due after the first premium. The **Policy** will not be terminated for nonpayment of premium during this grace period if the **Policyholder** pays all premiums due by the last day of this grace period. The **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of this grace period. No Policy Grace Period will be provided if **We** receive notice to terminate the **Policy** prior to a premium due date.

If **We** expressly agree to accept late payment of a premium without terminating the **Policy**, **We** do so in accordance with the Noncompliance With Policy Requirements provision in Section X of the **Policy**. In such case, the **Policyholder** will be liable to **Us** for any unpaid premiums for the time the **Policy** is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by **Us** in the collection of all overdue amounts.

WAIVER OF PREMIUM
During the period in which **You** are receiving a Temporary Total Disability Benefit or Continuous Total Disability Benefit, premiums will be waived from the first premium due date on or after the benefit begins to the premium due date following the date the benefit ceases, at which time premium payments must resume. If premium payments are not resumed on that date, **Your** coverage under the **Policy** shall terminate on that date. **You** are responsible for reporting Waiver of Premium to the **Policyholder** or an authorized person designated by the **Policyholder** or **Us**.

SECTION V - BENEFITS

ACCIDENTAL DEATH BENEFIT
If **Injury** to **You** results in death within the **Commencement Period**, **We** will pay the **Principal Sum** to the beneficiary in accordance with the Payment of Claims provision in Section IX of the **Certificate**.

SURVIVOR'S BENEFIT
If an Accidental Death Benefit is payable under the **Policy**, **We** will pay the **Monthly Benefit Amount**, up to the **Principal Sum**, to **Your** surviving **Spouse**.

If **You** are not survived by a **Spouse**, or if **Your Spouse** dies or remarries, **We** will pay or continue to pay the Survivor's Benefit to **Your** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. Payment of the **Monthly Benefit Amount** will end on the earliest of the following:
1. the date **Your Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date **Your** last **Dependent Child** dies or is no longer a **Dependent Child**; or
3. the date the **Principal Sum** has been paid.

If **You** are not survived by a **Spouse** or any **Dependent Child(ren)**, **We** will not pay a Survivor's Benefit.

For this benefit, the following definition applies:

Monthly Benefit Amount means the product of the Monthly Benefit Percentage shown in the **Schedule** multiplied by the **Principal Sum**.

EXPOSURE AND DISAPPEARANCE BENEFIT
If **You** are exposed to weather because of an **Accident**, which results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If **Your** body has not been found within one year after **Your** disappearance, stranding, sinking or wrecking of a power unit in which **You** were an occupant, then it will be presumed, subject to all other terms and provisions of the **Policy**, that **You** have suffered Accidental Death within the meaning of the **Policy**. If **You** are found and identified, **We** have the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT
If **Injury** to **You** results in any one of the **Losses** specified below within the **Commencement Period**, **We** will pay the Percentage of the **Principal Sum** shown below:

For **Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	[100%]
Sight of Both Eyes	[100%]
One Hand and One Foot	[100%]
One Hand and the Sight of One Eye	[100%]
One Foot and the Sight of One Eye	[100%]
One Hand or One Foot	[50%]
Sight of One Eye	[50%]
Thumb and Index Finger of Same Hand	[25%]
Speech and Hearing	[50%]
Speech or Hearing	[25%]

If more than one **Loss** is sustained by **You** as a result of the same **Accident**, only one amount, the largest, will be paid.

For this benefit, the following definition applies:

Loss, in the singular or plural, of a hand or foot means complete severance through or above the wrist or ankle joint; **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye; and **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

PARALYSIS BENEFIT
If **Injury** to **You** results in any Type of Paralysis specified below within the **Commencement Period**, **We** will pay the Percentage of the **Principal Sum** shown below:

Type of Paralysis:	Percentage of the **Principal Sum**
Quadriplegia	[100%]
Paraplegia	[75%]
Hemiplegia	[50%]
Uniplegia	[25%]

If **You** sustain more than one Type of Paralysis as a result of the same **Accident**, only the largest single amount will be considered a **Covered Loss**.

For this benefit, the following definitions apply:

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**.

Paraplegia means the complete and irreversible paralysis of both lower **Limbs**.

Hemiplegia means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body.

Uniplegia means the complete and irreversible paralysis of one **Limb**.

Limb, in the singular or plural, means entire arm or entire leg.

TEMPORARY TOTAL DISABILITY BENEFIT

If **Injury** to **You** results in **Temporary Total Disability** within the **Commencement Period** and **You** are under age [70] on the day the **Temporary Total Disability** begins, **We** will pay the following amount, after the **Waiting Period**:

1. for each week of a **Temporary Total Disability** during a **Single Period of Total Disability** the Temporary Total Disability Benefit is equal to the lesser of:
   a. the Benefit Percentage shown in the **Schedule** of the **Average Weekly Earnings**; or
   b. the **Maximum Weekly Benefit Amount**;
2. for less than a full **Benefit Week** of **Temporary Total Disability**, the Temporary Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. the date **You** are no longer **Temporarily Totally Disabled**;
2. the date **You** die;
3. the date the **Maximum Benefit Period** has been reached; or
4. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**.

For this benefit, the following definitions apply:

Average Weekly Earnings means:

1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income **You** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [thirty-three percent (33%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income **You** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [seventy-five percent (75%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [seventy-five percent (75%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation provided **You** were not an **Owner/Operator**. If **You** were an **Owner/Operator**, then **We** will use 33% of the gross income.]

You must produce proof of **Your** gross income and the number of weeks worked. Otherwise, **We** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the **Maximum Weekly Benefit Amount**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the first day of **Temporary Total Disability** after the **Waiting Period** and on the same day of each week thereafter.

Continuous Care means monthly monitoring or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Temporary Total Disability** on a monthly basis.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following, which are considered separate periods of disability:

1. successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which **You** are not **Temporarily Totally Disabled**; or
2. successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least six (6) months during which **You** are not **Temporarily Totally Disabled**.

Temporary Total Disability or Temporarily Totally Disabled means disability that:

1. prevents **You** from performing the **Material and Substantial Duties** of **Your** occupation [as a commercial truck driver];
2. requires the care and treatment of a **Physician**; and
3. requires that and results in **Your** receiving **Continuous Care**.

If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** shall not qualify for the Temporary Total Disability Benefit. During this period, **You** cannot engage in any activity which results in earned income.

Material and Substantial Duties means a duty or duties which **You** are required to perform under the terms of the written contract with the **Policyholder** or **Owner/Operator** and as described in **Your** application.

Offsets

Subject to the **Minimum Weekly Benefit Amount**, the Temporary Total Disability Benefit shall be reduced by:

1. Social Security disability benefits excluding any amounts for which **Your** dependents may qualify because of **Your** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; and
4. the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

You must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

CONTINUOUS TOTAL DISABILITY BENEFIT

If **Injury** to **You** resulting in **Temporary Total Disability** subsequently results in **Continuous Total Disability**, **We** will pay the following, after the **Waiting Period**:

1. for each month of a **Continuous Total Disability**, the Continuous Total Disability Benefit is four and three-tenths (4.3) times the **Weekly Benefit Amount** for **Temporary Total Disability**; or
2. for less than a full **Benefit Week** of **Continuous Total Disability**, the Continuous Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Continuous Total Disability**, but only if:
   a. Temporary Total Disability Benefits ceased solely because the **Maximum Benefit Period** has been reached, but **You** remain disabled;
   b. **You** are not within six (6) months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration, on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached;
   c. **You** have been granted a Social Security disability award for **Your** disability (if **You** cannot meet the credit requirement for a Social Security disability award **You** cannot qualify for the Continuous Total Disability Benefit even if **You** would otherwise qualify);
   d. **Your** disability is reasonably expected to continue without interruption until **You** die and is substantiated by objective medical evidence satisfactory to **Us**;
   e. the **Injury** resulting in a **Continuous Total Disability** occurred before **You** are within six (6) months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration; [and]

f. the **Injury** began within the **Commencement Period** [.] [; and]
g. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**.]

The Continuous Total Disability Benefit shall cease on the earliest of the following:
1. the date **You** are no longer **Continuously Totally Disabled**;
2. the date **You** die;
3. the date **Your** Social Security disability award ceases;
4. the date the **Maximum Benefit Period** has been reached;
5. the date that the **Maximum Benefit Amount** has been paid; or
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**.

For this benefit, the following definitions apply:
Average Weekly Earnings will be calculated as follows:
1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income **You** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [thirty-three percent (33%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income **You** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [seventy-five percent (75%)] of the average gross income received by the other **Insured Persons**, who were contracted within the last three (3) months prior to the covered **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [seventy-five percent (75%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation provided **You** were not an **Owner/Operator**. If **You** were an **Owner/Operator**, then **We** will use 33% of the gross income.]

You must produce proof of **Your** gross income and the number of weeks worked. Otherwise, **We** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the Maximum Weekly Benefit. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Total Disability or Continuously Totally Disabled means disability that:
1. prevents **You** from performing the duties of any occupation for which **You** are qualified by reason of education, training or experience;
2. requires the care and treatment of a **Physician**; and
3. requires that, and results in, **Your** receiving **Continuous Care**.

We must receive proof of continuing **Continuous Total Disability** on a quarterly basis; provided however, that **We** may waive requirements 2 and 3. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** shall not qualify for **Continuous Total Disability**. During this period, **You** cannot engage in any activity which results in earned income.

Continuous Care means at least quarterly monitoring or evaluation of the disabling condition by a **Physician**.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Continuous Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which **Your** dependents may qualify because of **Your** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; or
4. the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

You must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

ACCIDENT MEDICAL EXPENSE BENEFIT
If **You** suffer an **Injury** requiring treatment by a **Physician** within the **Commencement Period**, **We** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Services or Charges** received or incurred due to such **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** for all **Injuries** caused by a single **Accident**, subject to any applicable **Deductible Amount**.

For this benefit, the following definitions apply:
Ambulatory Medical Center means a facility that:
1. operates under the laws of the state in which it is situated;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility.

Ambulatory Medical Center does not include a **Hospital**, **Physician's** office or clinic.

Custodial Services means any services which are not intended primarily to treat a specific injury. **Custodial Services** include, but shall not be limited to, services:
1. related to watching or protecting **You**;
2. related to performing or assisting **You** in performing any activities of daily living, such as:
   a. walking;
   b. grooming;
   c. bathing;
   d. dressing;
   e. getting in or out of bed;
   f. toileting;
   g. eating;
   h. preparing foods; or
   i. taking medications that can usually be self-administered; and
3. that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment means equipment of a type that is designed primarily for use by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a spa or a stationary bicycle).

Deductible Amount means the total amount of **Medically Necessary Services or Charges** that must be paid by **You** before any Accident Medical Expense Benefit is paid under the **Policy**. **We** shall not be responsible for any **Medically Necessary Services or Charges** within the **Deductible Amount** as set forth in the **Schedule**.

Extended Care Facility means an institution that meets all of the following requirements:
1. operates under the laws of the state that it is situated in;
2. is approved by the United States Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a registered nurse;
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment of **You** in **Your** home as part of a treatment plan prescribed by the attending **Physician**, which is provided by a **Hospital** or agency certified to provide such services, but only if it:

1. begins within [seven (7)] days after discharge from a **Hospital**; and
2. follows a **Hospital** confinement of [five (5)] days or more.

Hospital means a facility that:
1. operates under the law of the state in which it is situated;
2. is approved by the United States Department of Health and Human Services or its successor;
3. has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
4. has 24-hour nursing service by registered nurses on duty or on call; and
5. is supervised by one or more **Physicians**.

A **Hospital** does not include:
1. a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care;
2. a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, or any ward, room, wing or other section of a hospital that is used for such purposes; or
3. any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Medically Necessary Services or Charges means one or more of the following, but only if each: (a) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (b) meets generally accepted standards of medical practice; and (c) is ordered by a **Physician** and performed under his or her care, supervision or order:
1. **Hospital** room and board charges or room and board charges in an intensive care unit; **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room); use of an **Ambulatory Medical Center**; and **Hospital** charges for in-patient treatment of a **Mental and Nervous or Depressive Condition**, as shown in the **Schedule**;
2. treatment by a **Physician** of a covered **Mental and Nervous or Depressive Condition** due to an **Injury**, as shown in the **Schedule**;
3. Ambulance service to or from a **Hospital**, as shown in the **Schedule**;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. Physical, Occupational or Work Hardening Therapies, Chiropractic Care and Acupuncture, as shown in the **Schedule**;
9. **Durable Medical Equipment** rental charges, up to the actual purchase price of such equipment;
10. the initial supply, but not any replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes;
11. medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
12. repair or replacement of **Sound Natural Teeth** damaged or lost as a result of **Injury**, up to the Dental Benefit Maximum, if any, shown in the **Schedule**;
13. **Extended Care Facility**; or
14. **Home Health Care**.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary Services or Charges** for the care and treatment of the **Injury**, including but not limited to: (1) a non-essential private **Hospital** room; (2) television rental; and (3) **Hospital** telephone charges.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary Charge(s) means an amount(s) that:
1. does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and
2. does not include charges that would not have been made if no insurance existed[; and
3. does not exceed the cost of a generic drug, if available. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available].

ACCIDENT MEDICAL EXPENSE BENEFIT EXCLUSIONS
In addition to the General Exclusions and Limitations in Section VIII of the **Policy**, **Medically Necessary Services or Charges** do not include expenses for or resulting from any of the following:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
2. dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. eye glasses or contact lenses;
4. hearing aids or hearing examinations;
5. rental of **Durable Medical Equipment** if the total rental expense exceeds the usual purchase price for similar equipment in the locality where the expense is incurred, unless authorized by **Us**;
6. **Custodial Services**;
7. **Personal Comfort or Convenience Items**;
8. services of any government **Hospital** for which **You** are not liable for payment;
9. any expenses covered by [Medicare, Medicaid,] a **Third Party** [or any other insurance];
10. expenses incurred which are more than the **Usual and Customary Charge**;
11. cosmetic, plastic or restorative surgery unless otherwise covered;
12. expenses which **You** are not legally obligated to pay;
13. an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;
14. any mileage costs or lodging expenses, unless authorized by **Us**;
15. any translation costs, unless authorized by **Us**; or
16. **Home Health Care** services provided by an **Immediate Family Member** or **Household Member**.

SECTION VI - ADDITIONAL BENEFITS

[**RETURN OF REMAINS BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay for the transport of **Your** body or remains (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of **Your** body or remains to **Your** county of residence. **We** must be contacted prior to the transportation of **Your** body or remains and **We** must pre-authorize the transportation for coverage to apply. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**NON-MEDICAL REPATRIATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accident Medical Expense Benefit and have sufficiently recovered to travel in a regularly scheduled economy class air flight, commercial bus or train and without special medical equipment or personnel with a minimal risk to **Your** health, **We** will pay for the return to **Your** principal residence. **We** must be contacted prior to the transport and **We** must agree to the travel itinerary for coverage to apply. This benefit is subject to the prior recommendation of the attending **Physician**. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**AFTER SCHOOL CARE BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit for after school care to the individual who incurs the expense on behalf of each **Dependent Child** who is [ten (10)] years old or less, up to a maximum of the lesser of:
1. [two percent (2%)] of the applicable **Principal Sum** paid under the Accidental Death Benefit per year; or
2. [two thousand dollars ($2,000)] per year.

The after school care provider may not be an **Immediate Family Member** and written proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, to establish continued eligibility for this benefit.

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child** is under age [ten (10)] at the time of each payment. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**COMA BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** and within three hundred sixty-five (365) days of the **Accident** which caused such **Injury**, such **Injury** causes **You** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay an

additional benefit equal to [one percent (1%)] of the **Principal Sum** for such **Injury**, and such amount will be paid each month **You** remain in a **Coma** following the initial thirty-one (31) day period. At the end of eleven (11) months of payment, if **You** remain in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the eleven (11) months of benefit already received.

The Coma Benefit will end on the earliest of the following:
1. the date **You** are no longer in the **Coma**; or
2. the date **You** have received a Coma Benefit for eleven (11) months.

We may require receipt of written proof, at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Coma means a condition determined as such by **Our** duly licensed **Physician**.]

[**CRITICAL BURN BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss**, **We** will pay an additional benefit equal to the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)], but only if **You**:
1. suffered second degree or higher burns over [twenty-five percent (25%)] of **Your** body; and
2. have undergone reconstructive surgery to treat the burned areas of **Your** body within three hundred sixty-five (365) days of the occurrence of the **Accident** that caused the **Injury**.]

[**DAY CARE BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense for each **Dependent Child** if:
1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and
2. the **Dependent Child** is under age [thirteen (13)].

The Day Care Benefit will be equal to the lesser of:
1. the actual cost of the day care;
2. [three percent (3)%] of the **Principal Sum**; or
3. [three thousand dollars ($3,000)];

and will be paid annually for [four (4)] consecutive years if:
1. the **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. written proof acceptable to **Us** is received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Accredited Child Care Facility means a properly licensed childcare facility that operates pursuant to state and local laws and has a Tax Identification Number issued by the Internal Revenue Service. **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**FELONIOUS ASSAULT BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** for an **Occupational Injury** payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Paralysis Benefit as a result of a **Felonious Assault** by someone other than **Yourself**, **You** or an **Immediate Family Member** or **Household Member**, **We** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum**, but only if:
1. the **Felonious Assault** occurs while **You** are under **Dispatch**; and
2. the crime directly involves the **Policyholder's** or **Your** funds or assets.

For this benefit, the following definition applies:

Felonious Assault means the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]

[**HIGHER EDUCATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay a benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**, but only if on the date of the **Accident**, the **Dependent Child**:
1. is enrolled as a full-time student in an accredited college, university or trade school; or
2. is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The Higher Education Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit for all **Dependent Child(ren)** combined is [twenty thousand dollars ($20,000)].]]

[**HIJACKING BENEFIT**
The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions and Limitations of the **Policy** is modified and an **Injury** directly resulting from a **Hijacking** or any attempt at any **Hijacking** is covered under the **Policy**.

This benefit will continue beyond the actual **Hijacking** while **You** are:
1. subject to the control of the person(s) making the **Hijacking**; and
2. traveling directly to **Your** home or original destination.

For this benefit, the following definition applies:

Hijacking means the unlawful seizure or wrongful exercise of control of a power unit occupied by **You**, while **You** are getting into, riding in, or getting out of and while under **Dispatch**.]

[**VEHICLE MODIFICATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Dismemberment Benefit or Paralysis Benefit, **We** will pay an additional benefit equal to the actual cost for modifications to **Your** motor vehicle that are necessary to make it accessible or drivable, but only if such **Injury** requires **You** to use a wheelchair. Benefits are not payable unless:
1. the modifications are made by a person(s) experienced in such modifications and are recommended by an organization recognized for providing support and assistance to wheelchair users; and
2. proof sufficient to **Us** is received by **Us**, establishing eligibility for this benefit.

The maximum amount payable under this benefit will be the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)].]

[**SEAT BELT BENEFIT**
If **You** suffer an **Injury** directly resulting from an automobile **Accident** resulting in a **Covered Loss** payable under the Accidental Death Benefit or Survivor's Benefit, **We** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum** up to a maximum of [ten thousand dollars ($10,000)], but only if **You** were:
1. operating or riding as a passenger in a motorized vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Accident**.

Your actual use of the seat belt or lap and shoulder restraints must be verified in the official law enforcement report of the **Accident**, through certification by the investigating officers; or by other reasonable proof, acceptable to **Us**.]

[**SPOUSE RETRAINING BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit to **Your Spouse** for the actual cost of any state licensed professional or trade-training program in which **Your Spouse** enrolls and completes, but only if the purpose of the program is to obtain an independent source of support and maintenance and the actual cost is incurred within [thirty (30)] months from **Your** death.

The Spouse Retraining Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if **Your Spouse** continues his or her training. Before this benefit is paid each year, proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit is [twenty thousand dollars ($20,000)].]

SECTION VII - LIMITS OF LIABILITY

The **Combined Single Limit of Liability** shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Loss** with respect to **You** arising out of **Injury** sustained by **You** as the result of any one **Accident** or Occurrence. The term Occurrence means a single event or related events or originating cause occurring within a 24-hour period.

The **Aggregate Limit of Liability** shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

If either the **Combined Single Limit of Liability** or the **Aggregate Limit of Liability** is not enough to pay all **Covered Loss**, **We** will pay reduced benefit amounts based upon the proportion that the **Covered Loss** bears to each benefit or expected total benefits that would otherwise be payable. If the total benefits are unknown, **We** will determine the total expected benefits for **You**.

Limitation on Multiple **Covered Loss**. If **You** suffer more than one **Covered Loss** under one benefit as a result of the same **Accident**, **We** will pay only up to the largest **Covered Loss** amount.

Limitation on Multiple Benefits. If **You** can recover benefits under two or more of the Accidental Death Benefit, Accidental Dismemberment Benefit, [Coma Benefit] or the Accidental Paralysis Benefit as a result of the same **Accident**, **We** will pay only up to the highest applicable **Principal Sum**.

SECTION VIII - GENERAL EXCLUSIONS AND LIMITATIONS

The **Policy** does not cover any losses contributed to or caused by, in whole or in part, by any of the following:
1. [suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** or any **Injury** resulting from a provoked attack;]
2. [sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning [or routine and temporary non chronic sickness or illness such as a cold, cough, headache or nausea];]
3. [a **Pre-existing Condition**, until **You** have been continuously covered under the **Policy** for [twelve (12)] consecutive months;]
4. [**Occupational Cumulative Trauma** or **Cumulative Trauma and Repetitive Conditions**, unless shown in the **Schedule**;]
5. [**Occupational Disease**, unless shown in the **Schedule**;]
6. [performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;]
7. [declared or undeclared war, or any act of declared or undeclared war;]
8. [full-time active duty in the armed forces of any country or international authority;]

9. [any **Injury** for which **You** are entitled to benefits pursuant to any workers' compensation law or other similar legislation;]
10. [any loss insured by employers' liability insurance;]
11. [**You** being intoxicated:
    a. **You** are conclusively deemed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether **You** are in fact operating a motor vehicle when the **Injury** occurs; and
    b. an autopsy report from a licensed medical examiner, law enforcement officer reports or similar items will be considered proof of **Your** intoxication;]
12. [**You** being under the influence of any illegal substance, drug, narcotic, or hallucinogen, unless such drug, narcotic, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage;]
13. [**Your** commission of or attempt to commit a felony or a Class A misdemeanor;]
14. [travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if **You** are:
    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or **You**;]
15. [skydiving, parasailing, hang-gliding, bungee-jumping [or any similar activity];] [or]
16. [charges incurred for treatment of a covered **Injury**, when **You** obtain compensation for the covered **Injury** from a **Third Party**].

[INCARCERATION LIMITATION
Benefits provided to **You** will cease while **You** are incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when **You** are released from such facility.]

SECTION IX - CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be received by **Us** within twenty (20) days after **Your** loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to **Us** at Zurich American Insurance Company Group Accident Claims Division, [P.O. Box 968041 Schaumburg, IL 60196] with information sufficient to identify **You**, is deemed notice to **Us**.

CLAIM FORMS
We will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within thirty (30) days after the giving of notice, the claimant will be deemed to have met the Proof of Loss requirements upon submitting, within the time fixed in the **Policy** for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include **Your** name, the **Policyholder's** name and the Policy Number.

PROOF OF LOSS
Written Proof of Loss acceptable to **Us** must be received by **Us** within ninety (90) days after the date of the loss. If the loss is one for which the **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proof acceptable to **Us** must be received by **Us**, at such intervals as **We** may reasonably require, establishing continued eligibility for the benefit. Failure to furnish such proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time such proof is otherwise required. **We** have a right to investigate any documents that **You** shall make available to **Us** upon request.

PAYMENT OF CLAIMS
Upon receipt of written proof of death, payment for loss of life of **You** will be made to **Your** beneficiary or, if there is no beneficiary designated, **Your** survivors in the following order:
1. **Your Spouse**;
2. **Your** child(ren);
3. **Your** parents;
4. **Your** brothers and sisters;
5. **Your** estate.

Upon receipt of written Proof of Loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) **You**. If **You** die before all payments due have been made, the amount still payable will be paid to **Your** beneficiary or, if there is no beneficiary designated, **Your** survivors in the order as listed above.

BENEFICIARY DISIGNATION AND CHANGE
Your designated beneficiary(ies) is (are) the person(s) so named by **You** as shown on the **Policyholder's** records kept on the **Policy**.

A legally competent **Insured Person** over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the **Policyholder** with a written request for change. When the request is received by the **Policyholder**, whether the **Insured Person** is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to **Us** on account of any payment which is made prior to receipt of the request.

Except for the Survivor's Benefit, if there is no designated beneficiary or no designated beneficiary is living after **Your** death, payment will be made to **Your** estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding one thousand dollars ($1,000) may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

We shall pay benefits directly to any **Hospital** or person rendering covered services, unless **You** request otherwise in writing and provides proof that payment was made directly to such **Hospital** or person. Such request must be made no later than the time Proof of Loss is filed. Any payment **We** make in good faith fully discharges **Our** liability to the extent of the payment made.

TIME OF PAYMENT OF CLAIM
Benefits payable under the **Policy** for any loss other than loss for which the **Policy** provides any periodic payment will be paid within thirty (30) days upon **Our** receipt of written Proof of Loss. Benefits payable periodically under the **Policy** will be paid at four (4) week intervals during the continuance of the period for which **We** are liable, subject to **Our** receipt of written Proof of Loss, and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

REHABILITATION
We will consider paying for a rehabilitation program for **You** based on an **Occupational Assessment** provided **You** are receiving benefits under either the **Temporary Total Disability Benefit** or the **Continuous Total Disability Benefit**. The rehabilitation program must be mutually agreed upon by **You** and **Us**. The extent of **Our** participation will be determined solely by **Us**. Any benefits payable will continue during **Your** rehabilitation unless otherwise agreed to by **Us**.

SUNSET
In no event shall benefits under the **Policy** be payable unless written Proof of Loss is received by **Us** within [three (3) years] from the date of the **Accident**.

[**ARBITRATION**
Any contest to a claim denial under the **Policy** shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration shall occur at the offices of the American Arbitration Association nearest to **You** or the person claiming to be the beneficiary. The arbitrator(s) shall not award consequential or punitive damages in any arbitration under this section. This provision does not apply if **You** or the person claiming to be the beneficiary is a citizen of a state where the law does not allow binding arbitration in an insurance policy but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. [Non-binding arbitration is required and no legal action may be brought by **You**, the beneficiary, or Us until thirty (30) days after the arbitrator(s) issues a non-binding award.] This provision bars the institution of any individual or class action lawsuit brought by **You** or the beneficiary.]

SECTION X - GENERAL PROVISIONS

ENTIRE CONTRACT
The **Policy**, together with any riders, endorsements, amendments, applications, enrollment forms and attached papers, if any, make up the entire contract between the **Policyholder** and **Us**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by **You** will be used in any contest unless a copy of the statement is furnished to **You** or **Your** beneficiary or personal representative.

No changes in the **Policy** will be valid until approved by an officer of **Our's**. The approval must be noted on or attached to the **Policy**. No agent may change the **Policy** or waive any of its provisions.

CERTIFICATE OF INSURANCE
We will provide the **Policyholder** with a Certificate of Insurance, in either paper or electronic format, for delivery to each **Insured Person**, where required by state law. Such Certificate of Insurance will contain a summary of terms that affect benefits.

INCONTESTABILITY
The validity of the **Policy** will not be contested after it has been in force for two year(s) from the Policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

POLICYHOLDER RECORDS
The **Policyholder** will keep a record of the coverage, premium, beneficiary designation and other pertinent administrative information for each **Insured Person** which, if acceptable to **Us**, shall be deemed to be a part of the **Policy**. **We** may examine these records at any reasonable time while the **Policy** is in force and for six (6) years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured Person**. [The **Policyholder** shall indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the administration described herein.]

PHYSICAL EXAMINATION AND AUTOPSY
We have the right, at **Our** own expense, to examine the **Insured Person** whose **Injury** is the basis of a claim, when and as often as it may be reasonably required while a claim is pending. **We** may also require an autopsy where it is not prohibited by law.

LEGAL ACTIONS
In those states where binding arbitration is not allowed, no legal action for a claim can be brought against **Us** until sixty (60) days after receipt of written Proof of Loss. In those states where binding arbitration is not allowed, no legal action for a claim can be brought against **Us** more than three (3) years (six (6) years in South Carolina and Wisconsin, five (5) years in Kansas, Florida and Tennessee) after the time for giving written Proof of Loss. In those states where binding arbitration is allowed, binding arbitration shall supersede this provision.

NONCOMPLIANCE WITH POLICY REQUIREMENTS
Any express waiver by **Us** of any requirements of the **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

CONFORMITY WITH STATE STATUTES
Any provision of the **Policy** that, on its effective date, is in conflict with the statutes of the state in which the **Policy** was delivered, is hereby amended to conform to the minimum requirements of such laws.

CLERICAL ERROR
Clerical error, whether by the **Policyholder**, the Producer or **Us**, in keeping records pertaining to the **Policy**, will not:
1. invalidate coverage otherwise validly in force; or
2. continue coverage otherwise validly terminated.

DATA REQUIRED
The **Policyholder** must maintain adequate records acceptable to **Us** and provide any information required by Us relating to this insurance.

AUDIT
We will have the right to inspect and audit, at any reasonable time, all records and procedures of the **Policyholder** that may have a bearing on this insurance.

ASSIGNMENT
The **Policy** is non-assignable.

SUBROGATION
We have the right to recover all payments including future payments, which **We** have made to **You** or on behalf of **Your** covered dependents, heirs, guardians or executors or will be obligated to pay in the future to **You**, from any **Third Party**. If **You** recover from any **Third Party**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to **You**. **You** agree to assist **Us** in preserving **Our** rights against any **Third Party**, including but not limited to, signing subrogation forms supplied by **Us**.

[**MADE WHOLE DOCTRINE**
We have the right to recover any and all first monies paid (or payable) to or on behalf of **You** and to any and all claims of or on behalf of **You**, to the extent of benefits paid by the **Policy**, and regardless of whether or not the beneficiary has been made whole. Made whole shall include first dollar recovery with no offset for attorneys' fees.]

RIGHT TO RECOVER OVERPAYMENTS
In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** shall have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to **You** (and **Your** assignee) under the **Policy** to the extent of the overpayment.

CONDITIONAL CLAIM PAYMENT
If **You** suffer a **Covered Loss** as the result of an **Injury** for which a **Third Party** may be liable, **We** will pay the amount of benefits otherwise payable under the **Policy**. However, if **You** receive payment from the **Third Party**, **You** agree to refund to **Us** the lesser of:
1. the amount actually paid by **Us** for such **Covered Loss**; or
2. an amount equal to the sum actually received from the **Third Party** for such **Covered Loss**.

If **You** do not receive payment from the **Third Party** for such **Covered Loss**, **We** reserve the right to subrogate under the Subrogation clause of the **Policy**.

At the time such **Third Party** liability is determined and satisfied, this amount shall be paid whether determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.

[**CLAIMS FOR WORKERS' COMPENSATION AND OTHER INSURANCE**
No benefits shall be payable under the **Policy** for any loss for which **You** claim or file for any workers' compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, **We** shall determine **Our** liability under the **Policy**. **We** reserve the right to recover, from **You**, any benefits paid under the **Policy** that are subsequently paid for under any workers' compensation, employers' liability, occupational disease or similar law or any other insurance.]

[Workers' Compensation Indemnification. If **You** are determined by a court of law or the appropriate state regulatory authority to be covered under workers' compensation insurance for a **Covered Loss**, any benefits for which **You** are eligible under the **Policy**, are payable to the person who was determined to be **Your** employer or such person's designee or assignee.]

SECTION XI – IMPORTANT NOTICE

You may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if You need assistance in resolving any complaints. Or, You may write to Zurich American Insurance Company at their administrative offices at [XXXXXX].

Should You wish to contact the Arkansas Insurance Department for assistance, You may do so by calling [1-800-282-9134]. Or, You may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

SERFF Tracking Number:	*ZURC-126350669*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*43840*
Company Tracking Number:	*CW AH 29187*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Occupational Accident Insurance Policy - Forms*		
Project Name/Number:	*CW AH 29187 - Occupational Accident Insurance Policy - Forms/CW AH 29187*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/21/2009	Form	[Truckers] [Occupational] Accident Insurance Policy	11/04/2009	U-OA-400-A AR - [Truckers][Occupational] Accident Policy.pdf (Superceded)
10/21/2009	Form	[Truckers] [Occupational] Accident Insurance Certificate	11/04/2009	U-OA-402-A AR - [Truckers][Occupational] Accident Certificate.pdf (Superceded)

[Truckers] [Occupational] Accident Insurance Policy

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

This **Policy** is a legal contract between the **Policyholder** and the **Company**. The **Company** agrees to insure eligible persons of the **Policyholder** (herein called **Insured Person(s)**) against loss covered by this **Policy**, subject to its provisions, limitations and exclusions. The persons eligible to be **Insured Persons** are all persons described in the eligibility section of the **Schedule**.

This **Policy** is issued in consideration of the payment of the required premium when due and the statements set forth in the signed Group Application, which is attached to and made part of this **Policy** and in the individual enrollment forms, if any.

This **Policy** begins on the Policy Effective Date shown in the **Schedule**. This **Policy** will continue in effect, provided premiums are paid when due, until the Policy Termination Date set forth in the **Policy**, unless otherwise terminated as further provided in this **Policy**, or renewed.

Please refer to the **Policy** for the special meaning of words and phrases that appear in bold.

Various provisions in this **Policy** restrict coverage. Read the entire **Policy** carefully to determine an **Insured Person's** rights and duties and what is and is not covered.

THIS POLICY PROVIDES ACCIDENT COVERAGE ONLY
THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

IMPORTANT NOTICE
THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.

This **Policy** is governed by the laws of the state in which it is delivered.

In return for the payment of premium, and subject to the terms of this **Policy**, coverage is provided as stated in this **Policy**.

IN WITNESS WHEREOF, this **Company** has executed and attested these presents and, where required by law, has caused this **Policy** to be countersigned by its duly Authorized Representative(s).

Nancy D. Mueller

President

Corporate Secretary

PLEASE READ THIS POLICY CAREFULLY

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THIS POLICY IS NOT WORKERS' COMPENSATION AND DOES NOT REQUIRE PRE-AUTHORIZATION OF A PHYSICIAN FOR COVERED SERVICES OR TREATMENT. THE INSURED PERSON MAY CONSULT THE COMPANY AT [1-888-889-5330] TO DETERMINE IF A SERVICE OR TREATMENT IS COVERED. THE COMPANY CAN PROVIDE THE INSURED PERSON WITH THE NAME AND ADDRESS OF A PHYSICIAN WHO IS A PREFERRED PROVIDER.

THE **INSURED PERSON** CANNOT BE COVERED BY ANY OTHER OCCUPATIONAL ACCIDENT POLICY ISSUED BY THE **COMPANY**. IF THE **INSURED PERSON** PAYS PREMIUM BUT IS NOT ELIGIBLE FOR COVERAGE OR DOES NOT QUALIFY FOR BENEFITS UNDER THIS **POLICY**, THE **COMPANY** WILL REFUND ANY UNEARNED PREMIUM PAID IN ERROR.

SECTION I - SCHEDULE

Policy Effective Date: [01/01/09]
[**Policy Period**: [01/01/09] to [01/01/10]]
Policy Premium Due Date: [01/01/09]
Policy Number: [XXXXXX-XX]

Insured Person's Premium: [$0.00]

Policyholder: [Name of Trucking Company]
[Address]
[City, State, Zip]

Eligible Persons

The following persons are eligible to become **Insured Persons** under this **Policy**:

CLASS I: **Actively at Work Owner/Operators** who have enrolled for coverage under this **Policy**.
CLASS II: **Actively at Work Contract Drivers** who have enrolled for coverage under this **Policy**.

Benefits Summary

	Occupational Injuries	**Non-Occupational Injuries**
☐ Accidental Death Benefit:		
Principal Sum*	[$50,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Survivor's Benefit:		
Principal Sum*	[$175,000.00]	[$7,500.00]
Monthly Benefit Percentage of **Principal Sum**	[1.0%]	[1.0%]
Monthly Benefit Amount	[$1,750.00]	[$1,750.00]
☐ Accidental Dismemberment Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accidental Paralysis Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accident Medical Expense Benefit:		
Commencement Period	[90 days]	[90 days]
Deductible Amount	[$0.00]	[$0.00]
Maximum Benefit Amount	[$1,000,000.00]	[$5,000.00]
Maximum Benefit Period	[104 weeks]	[52 weeks]
Dental Benefit Maximum	[$2,500.00]	[$1,000.00]
Lifetime **Maximum Benefit Amount**	[$1,000,000.00]	[$10,000.00]
Physical, Occupational, or Work Hardening Therapies	To a maximum-combined [36] visits	[N/A]
Ambulance for Medically Necessary Services	[1] round trip to and from a **Hospital** to a Maximum	[1] round trip to and from a **Hospital** to a Maximum

	Occupational Injuries of [$10,000.00] per **Accident**	**Non-Occupational Injuries** of [$10,000.00] per **Accident**
Acupuncture Care and Chiropractic Care	[$1,000.00] per **Injury**	N/A
[Hernia Coverage]	[$10,000.00]	N/A
[Hemorrhoid Coverage]	[$10,000.00]	N/A
Mental and Nervous or Depressive Condition	1 visit per day to a maximum of [$25.00] per visit and [20] visits per **Accident**	N/A
[**Occupational Cumulative Trauma**]	[$20,000.00]	N/A
[**Occupational Disease**]	[$20,000.00]	N/A
☐ Temporary Total Disability Benefit:		
Commencement Period	[90 days]	[90 days]
Waiting Period	[7 days]	[7 days]
Benefit Percentage	[70.0%]	[70.0%]
Minimum Weekly Benefit Amount	[$125.00]	[$125.00]
Maximum Weekly Benefit Amount	[$500.00]	[$500.00]
Maximum Benefit Period**	[104 weeks]	[12 weeks]
[**Maximum Benefit Period** for Hernia]	[90 days]	N/A
[**Maximum Benefit Period** for Hemorrhoid]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Disease**]	[90 days]	N/A
☐ Continuous Total Disability Benefit: ***		
Waiting Period	[equals **Maximum Benefit Period** for **Temporary Total Disability**]	N/A
Benefit Percentage	[70.0%]	N/A
Minimum Weekly Benefit Amount	[$50.00]	N/A
Maximum Weekly Benefit Amount	[$500.00]	N/A
Maximum Benefit Amount	[$300,000.00]	N/A
Maximum Benefit Period	Up to age 70, but not beyond full Social Security retirement age	N/A
☐ Additional Benefits:		N/A
[Return of Remains Benefit]	[Refer to SECTION VI]	N/A
[Non-Medical Repatriation Benefit]	[Refer to SECTION VI]	N/A
[After School Care Benefit]	[Refer to SECTION VI]	N/A
[Coma Benefit]	[Refer to SECTION VI]	N/A
[Critical Burn Benefit]	[Refer to SECTION VI]	N/A
[Day Care Benefit]	[Refer to SECTION VI]	N/A
[Felonious Assault Benefit]	[Refer to SECTION VI]	N/A
[Higher Education Benefit]	[Refer to SECTION VI]	N/A
[Hijacking Benefit]	[Refer to SECTION VI]	N/A
[Vehicle Modification Benefit]	[Refer to SECTION VI]	N/A
[Seat Belt Benefit]	[Refer to SECTION VI]	N/A
[Spouse Retraining Benefit]	[Refer to SECTION VI]	N/A
Limits of Liability:		
Combined Single Limit of Liability	[$1,000,000.00]	[$10,000.00]
Aggregate Limit of Liability	[$2,000,000.00]	[$15,000.00]
Sub Limits of Liability:		

	Occupational Injuries	Non-Occupational Injuries
[**Combined Single Limit of Liability** for:		
[Hernia]	[$20,000.00]	N/A
[Hemorrhoid]	[$20,000.00]	N/A
[**Occupational Disease**]	[$50,000.00]	N/A
[**Occupational Cumulative Trauma**]	[$50,000.00]	N/A

* Starting at age [65], the **Principal Sum** shall be based on the following schedule:

Age at Date of Loss	Percent of **Principal Sum**
[65]	[80%]
[66]	[60%]
[67]	[40%]
[68]	[20%]
[69]	[15%]
[70 and over]	[10%]

** If an **Insured Person** suffers an **Injury** at or after age [70], the **Maximum Benefit Period** shall be [one (1) year].

*** If an **Insured Person** sustains an **Injury** within six months or less of attaining his or her full Social Security retirement age, as defined by the United States Social Security Administration, the **Insured Person** does not qualify for the Continuous Total Disability Benefit.

SECTION II - GENERAL DEFINITIONS

Accident means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while coverage is in effect under the **Policy**.

Actively at Work means under **Dispatch** for at least [30] hours each week.

Aggregate Limit of Liability shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

Assignment means the **Policyholder** has offered and the **Insured Person** has accepted a shipment of freight as recorded in the books and records of the **Policyholder** in the ordinary course of business.

Company means Zurich American Insurance Company.

Co-Owner means a person who has partial ownership of a vehicle operating as an **Owner/Operator**.

Combined Single Limit of Liability means, with respect to any one **Insured Person**, the maximum amount that the **Company** will pay for all **Covered Loss** under this **Policy** for or in connection with **Injury** to an **Insured Person** resulting from any one **Accident**. When the **Combined Single Limit of Liability** has been reached, no further benefits shall be payable under this **Policy**, with respect to that **Insured Person**, for or in connection with **Injury** sustained as the result of that one **Accident**.

Commencement Period means the period between the date of the **Accident** that caused the **Injury** and the date on which the **Covered Loss** must occur for benefits to be payable under the Accidental Death Benefit, the Accidental Dismemberment Benefit, Accidental Paralysis Benefit, Accident Medical Expense Benefit and/or the Temporary Total Disability Benefit.

Contract Driver means an individual who:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [is authorized by an **Owner/Operator** to operate a power unit owned or leased by an **Owner/Operator** and must neither own nor lease the power unit;]
3. [is compensated on a basis other than time expended in the performance of work;]

4. [is responsible for determining the route and time for **Assignment**;]
5. [has the principal duty to operate the power unit;]
6. [is classified as an independent contractor by the **Policyholder** and the **Owner/Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance, or for any other purpose, [unless workers' compensation coverage is not mandatory for such person as an employee of either the **Policyholder** or **Owner/Operator**];] and
7. [receives for federal income tax reporting purposes a 1099 and not a W-2].

Covered Loss, in the singular or plural, means one or more of the losses or expenses identified in Sections V and VI of this **Policy** that are not specifically excluded herein.

Cumulative Trauma or Repetitive Conditions means **Non-Occupational** conditions that impair the normal physiological function of the body over an extended period, but do not arise as the result of a single **Accident**.

Dependent Child(ren) means the **Insured Person's** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption, who are:
1. under age 19 or under age 23 if he or she [:] [(a)] is enrolled in accredited institution of higher learning on a full-time basis, [and (b) relies on the **Insured Person** for more than 50% of his or her support and is taken as a dependent on the Federal Income Tax Return of the **Insured Person**]; or
2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the **Insured Person** for support and maintenance as defined herein.

The **Company** may require proof of the **Dependent Child(ren)'s** incapacity and dependency within 60 days before the **Dependent Child(ren)** reached the age limit specified above. The **Company** may request that satisfactory proof of the **Dependent Child(ren)'s** continued incapacity and dependency be submitted to the **Company** on an annual basis.

Dispatch means the time during which an **Insured Person** is on **Assignment** or is performing tasks prior to or after an **Assignment** to prepare the contracted vehicle for a current or future **Assignment**. **Dispatch** must be authorized by the **Policyholder** and includes the following:
1. in route to pick up a load;
2. picking up a load;
3. in route to delivering a load;
4. unloading a load;
5. the waiting time for a load;
6. returning from delivering a load;
7. in route to, returning from or performing a pre-trip inspection as required by a recognized governmental agency and/or the contracted motor carrier;
8. [while performing vehicle maintenance or repairs on the contracted vehicle during any of the foregoing times; and]
9. [while performing verifiable vehicle maintenance or repairs on the contracted vehicle; and]
10. performing activities to comply with federal or state laws or to satisfy contracted motor carrier requirements.

Eligible Person(s) means a Class I or Class II individual described in the **Schedule**.

Household Member means a person who maintains residence at the same address as the **Insured Person** and is not an **Immediate Family Member**.

Immediate Family Member means an **Insured Person's Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, stepparent, brother, sister, stepbrother, stepsister, child, child who has been legally adopted, or stepchild.

Injury, in the singular or plural, means bodily injury caused by an **Accident**, which occurs while the **Insured Person** is covered under this **Policy** and the **Injury** must result directly and independently of all other causes, in a **Covered Loss**. All **Injuries** sustained by an **Insured Person** in any one **Accident** shall be considered a single **Injury**.

Insured Person(s) means an **Owner/Operator** or **Contract Driver**:
1. who is enrolled for coverage under this **Policy**;
2. who has paid the required premium when due; and
3. whose coverage is in effect under this **Policy**.

Maximum Benefit Amount means the maximum amount that the **Company** will pay under the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Amount** is shown in the **Schedule**.

Maximum Benefit Period means the maximum period that the **Company** will pay benefits, after the **Waiting Period**, under the Temporary Total Disability Benefit, the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Period** is shown in the **Schedule**.

Maximum Weekly Benefit Amount means the maximum amount that the **Company** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Maximum Weekly Benefit Amount** is shown in the **Schedule**.

Mental and Nervous or Depressive Condition means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.

Minimum Weekly Benefit Amount means the minimum amount that the **Company** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Minimum Weekly Benefit Amount** is shown in the **Schedule**.

Non-Occupational means benefits payable for an **Injury** due to an **Accident** sustained by an **Insured Person** while not under **Dispatch**.

Occupational means, with respect to an activity, **Accident**, incident, circumstance or condition involving an **Insured Person**, that the activity, **Accident**, incident, circumstance or condition occurs or arises out of or in the course of the **Insured Person** performing services within the course and scope of contractual obligations for the **Policyholder**, and while under **Dispatch**. **Occupational** does not encompass any period during the course of everyday travel to and from work, other than as allowed under **Dispatch**, or while on vacation.

Occupational Assessment means a test of vocational capabilities, including review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), and evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

Occupational Cumulative Trauma means bodily injury that impairs the normal physiological function of the body caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time and does not arise as the result of a single **Accident**, when:
1. such condition is diagnosed by a **Physician**;
2. the **Insured Person's** last day of last performance of the activities causing the bodily injury occurred while the **Insured Person's** coverage is in effect; and
3. such bodily injury resulted directly, and independently of all other causes, in a **Covered Loss**.

Occupational Disease means a sickness that results in disability or death, and is caused by exposure to environmental or physical hazards during the course of the **Insured Person's Occupational** activities, when:
1. such sickness is diagnosed by a **Physician** and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards;
2. exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which the **Insured Person** performs **Occupational** activities;
3. the **Insured Person's** last day of last exposure to the environmental or physical hazards causing such sickness occurs while the **Insured Person's** coverage is in effect; and
4. such exposure results directly and independently of all other causes in a **Covered Loss**.

Owner/Operator means an individual who leases to or from the **Policyholder** and:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [owns or leases a power unit;]
3. [is responsible for the maintenance and operating costs of the power unit, including, but not limited to fuel, repairs and supplies;]
4. [is compensated on a basis other than time expended in the performance of work;]
5. [is responsible for determining the route and time for **Assignment**;]
6. [has the right to select or reject the load;]

7. [has a written contract or **Assignment** from the **Policyholder** and is classified as an independent contractor by the **Policyholder** and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;] and
8. [receives for federal income tax reporting purposes a 1099 not a W-2].

Physician means a qualified medical doctor acting within the scope of his or her license who is not:
1. the **Insured Person**;
2. an **Immediate Family Member**;
3. a **Household Member**; or
4. a practitioner retained by the **Policyholder**.

Policy means this [Truckers] [Occupational] Accident Insurance Policy.

Policyholder means the entity named as **Policyholder** in the **Schedule**.

Policy Period means the period shown in the **Schedule**, subject to prior termination pursuant to Section III of this **Policy**.

Pre-Existing Condition means a condition for which an **Insured Person** has sought or received medical advice or treatment at any time during the twelve months immediately preceding his or her effective date of coverage under this **Policy**.

Principal Sum means the maximum amount that the **Company** will pay under the Accidental Death Benefit, the Survivor's Benefit, the Accidental Dismemberment Benefit or the Accidental Paralysis Benefit. The applicable **Principal Sum** is shown in the **Schedule** and is subject to the **Combined Single Limit of Liability** and the **Aggregate Limit of Liability**.

Schedule means SECTION I of this **Policy**.

Spouse means the **Insured Person's** legal spouse.

Third Party in the singular or plural means, but is not limited to, the following:
1. the party that caused the **Accident**, **Injury** or other medical condition and any insurer or indemnifier thereof;
2. the **Insured Person's** insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers; or
3. any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the **Accident**, **Injury** or other medical condition.

Waiting Period means the consecutive number of days an **Insured Person** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Policy**. Temporary Total Disability Benefits and Continuous Total Disability Benefits are [not] retroactive to the first day of disability. The **Waiting Period** is shown in the **Schedule**.

SECTION III - EFFECTIVE DATES AND TERMINATION DATES

Policy Effective and Termination Dates

1. Policy Effective Date. This **Policy** begins on the Policy Effective Date shown in the **Schedule** at 12:01 A.M. Standard Time at the address of the **Policyholder** where this **Policy** is delivered.

2. Policy Termination Date. This **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of:
   a. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   b. the date specified in the written notice of the **Company's** intent to terminate this **Policy**, which will be at least [thirty (30)] days after the date the **Company** sends such notice to the **Policyholder's** last known recorded address;
   c. the date specified in the written notice of the **Policyholder's** intent to terminate this **Policy**, which will be at least [thirty (30)]days after the date the **Policyholder** sends such notice to the **Company**; or
   d. at the expiration of the **Policy Period**.

If the **Company** terminates this **Policy**, any unearned premium will be returned on a pro-rata basis. If the **Policyholder** requests termination, the **Company** will return any unearned premium paid on a pro-rata basis. Termination will not affect any claim for a **Covered Loss** occurring prior to the effective date of termination.

Owner/Operator's Effective and Termination Dates

1. **Owner/Operator's** Effective Date. An **Owner/Operator's** coverage under this **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Owner/Operator** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Owner/Operator's** Termination Date: An **Owner/Operator's** coverage under this **Policy** ends on the earliest of:
   a. the date this **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   c. the date the **Owner/Operator** requests, in writing, that his or her coverage be terminated; or
   d. the date the **Owner/Operator** ceases to be an **Insured Person**.

Contract Driver's Effective and Termination Dates

1. **Contract Driver's** Effective Date. A **Contract Driver's** coverage under this **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Contract Driver** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Contract Driver's** Termination Date. A **Contract Driver's** coverage under this **Policy** ends on the earliest of:
   a. the date this **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of this **Policy**;
   c. the date the **Contract Driver** requests, in writing, that his or her coverage be terminated;
   d. the date the **Contract Driver** ceases to be an **Insured Person**; or
   e. the date the **Owner/Operator**, with whom the **Contract Driver** is under contract, ceases to be an **Insured Person** and/or whose contract with the **Policyholder** terminated.

A change in an **Insured Person's** coverage under this **Policy** due to a change in the **Insured Person's** eligible class or benefit selection becomes effective on the later of: (1) the date the change in his or her eligible class or benefit selection occurs; or (2) if premium change is required, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

SECTION IV - PREMIUMS

PREMIUMS

Premiums are payable to the **Company** in the amount shown in the **Schedule**. The **Company** may change the required premiums due by giving the **Policyholder** at least [sixty (60) days] advance written notice. The **Company** may change the required premiums as a condition of any renewal of this **Policy**. The **Company** may also change the required premiums at any time when any change affecting premiums is made in this **Policy**.

The **Company** may re-underwrite and may change the terms and conditions of this **Policy** including the premium rate on the date when the number of **Insured Persons** under this **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [fifteen percent (15%)] or more. The **Policyholder** shall provide the **Company** with written notice of

such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.

PLAN AND EXPOSURE CHANGES
The **Policyholder** must notify the **Company** of any subsidiary or affiliated company that is to be covered under this **Policy**. Such notice must be sent within [thirty (30) days] of the acquisition of such subsidiary or affiliated company. If such notice is not provided, the newly acquired entity will not be considered a part of the **Policyholder** and the owner/operators or contract drivers will not be **Insured Persons** until the date that notice is provided. The **Company** has the right to decline coverage or adjust premium based on the changing exposure.

INSURED PERSON'S PREMIUM
The **Insured Person's** Premium is shown in the **Schedule** and shall be payable as follows:
1. the **Insured Person** who enrolled on or prior to the fifteenth (15th) day of the month shall pay an amount equal to the full monthly premium. No premium shall be payable for the last full or partial month of coverage; and
2. the **Insured Person** who enrolled after the fifteenth (15th) day of the month shall pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, the **Insured Person** shall pay an amount equal to the monthly premium.

INSURED PERSON'S GRACE PERIOD
A grace period of [thirty-one (31) days] will be provided for the payment of any **Insured Person's** Premium due after the first premium. The **Insured Person's** coverage will not be terminated for non-payment of premium during this grace period if the **Insured Person** pays the premium due by the last day of this grace period. The **Insured Person's** coverage will terminate if the full amount of the premium due is not paid by the last day of this grace period.

POLICY GRACE PERIOD
A grace period of [thirty-one (31)] days will be provided for the payment of any premium due after the first premium. This **Policy** will not be terminated for nonpayment of premium during this grace period if the **Policyholder** pays all premiums due by the last day of this grace period. This **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of this grace period. No Policy Grace Period will be provided if the **Company** receives notice to terminate this **Policy** prior to a premium due date.

If the **Company** expressly agrees to accept late payment of a premium without terminating this **Policy**, the **Company** does so in accordance with the Noncompliance With Policy Requirements provision in Section X of this **Policy**. In such case, the **Policyholder** will be liable to the **Company** for any unpaid premiums for the time this **Policy** is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by the **Company** in the collection of all overdue amounts.

WAIVER OF PREMIUM
During the period in which an **Insured Person** is receiving a Temporary Total Disability Benefit or Continuous Total Disability Benefit, premiums will be waived from the first premium due date on or after the benefit begins to the premium due date following the date the benefit ceases, at which time premium payments must resume. If premium payments are not resumed on that date, the **Insured Person's** coverage under this **Policy** shall terminate on that date. The **Insured Person** is responsible for reporting Waiver of Premium to the **Policyholder** or an authorized person designated by the **Policyholder** or the **Company**.

SECTION V - BENEFITS

ACCIDENTAL DEATH BENEFIT
If **Injury** to the **Insured Person** results in death within the **Commencement Period**, the **Company** will pay the **Principal Sum** to the beneficiary in accordance with the Payment of Claims provision in Section IX of this **Policy**.

SURVIVOR'S BENEFIT
If an Accidental Death Benefit is payable under this **Policy**, the **Company** will pay the **Monthly Benefit Amount**, up to the **Principal Sum**, to the **Insured Person's** surviving **Spouse**.

If the **Insured Person** is not survived by a **Spouse**, or if the **Insured Person's Spouse** dies or remarries, the **Company** will pay or continue to pay the Survivor's Benefit to the **Insured Person's** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. Payment of the **Monthly Benefit Amount** will end on the earliest of the following:

1. the date the **Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date the last **Dependent Child** dies or is no longer a **Dependent Child**; or
3. the date the **Principal Sum** has been paid.

If the **Insured Person** is not survived by a **Spouse** or any **Dependent Child(ren)**, the **Company** will not pay a Survivor's Benefit.

For this benefit, the following definition applies:

Monthly Benefit Amount means the product of the Monthly Benefit Percentage shown in the **Schedule** multiplied by the **Principal Sum**.

EXPOSURE AND DISAPPEARANCE BENEFIT

If an **Insured Person** is exposed to weather because of an **Accident**, which results in a **Covered Loss**, the **Company** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the body of the **Insured Person** has not been found within one year after the disappearance, stranding, sinking or wrecking of a power unit in which he or she was an occupant, then it will be presumed, subject to all other terms and provisions of this **Policy**, that the **Insured Person** has suffered Accidental Death within the meaning of this **Policy**. If the **Insured Person** is found and identified, the **Company** has the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to the **Insured Person** results in any one of the **Losses** specified below within the **Commencement Period**, the **Company** will pay the Percentage of the **Principal Sum** shown below:

For **Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	[100%]
Sight of Both Eyes	[100%]
One Hand and One Foot	[100%]
One Hand and the Sight of One Eye	[100%]
One Foot and the Sight of One Eye	[100%]
One Hand or One Foot	[50%]
Sight of One Eye	[50%]
Thumb and Index Finger of Same Hand	[25%]
Speech and Hearing	[50%]
Speech or Hearing	[25%]

If more than one **Loss** is sustained by an **Insured Person** as a result of the same **Accident**, only one amount, the largest, will be paid.

For this benefit, the following definition applies:

Loss, in the singular or plural, of a hand or foot means complete severance through or above the wrist or ankle joint; **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye; and **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

PARALYSIS BENEFIT

If **Injury** to the **Insured Person** results in any Type of Paralysis specified below within the **Commencement Period**, the **Company** will pay the Percentage of the **Principal Sum** shown below:

Type of Paralysis:	Percentage of the **Principal Sum**

Quadriplegia	[100%]
Paraplegia	[75%]
Hemiplegia	[50%]
Uniplegia	[25%]

If the **Insured Person** sustains more than one Type of Paralysis as a result of the same **Accident**, only the largest single amount will be considered a **Covered Loss**.

For this benefit, the following definitions apply:

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**.

Paraplegia means the complete and irreversible paralysis of both lower **Limbs**.

Hemiplegia means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body.

Uniplegia means the complete and irreversible paralysis of one **Limb**.

Limb, in the singular or plural, means entire arm or entire leg.

TEMPORARY TOTAL DISABILITY BENEFIT

If **Injury** to the **Insured Person** results in **Temporary Total Disability** within the **Commencement Period** and the **Insured Person** is under age [70] on the day the **Temporary Total Disability** begins, the **Company** will pay the following amount, after the **Waiting Period**:

1. for each week of a **Temporary Total Disability** during a **Single Period of Total Disability** the Temporary Total Disability Benefit is equal to the lesser of:
   a. the Benefit Percentage shown in the **Schedule** of the **Average Weekly Earnings**; or
   b. the **Maximum Weekly Benefit Amount**;
2. for less than a full **Benefit Week** of **Temporary Total Disability**, the Temporary Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. the date the **Insured Person** is no longer **Temporarily Totally Disabled**;
2. the date the **Insured Person** dies;
3. the date the **Maximum Benefit Period** has been reached; or
4. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to the **Company**.

For this benefit, the following definitions apply:

Average Weekly Earnings means:

1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income the **Insured Person** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income the **Insured Person** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will

use [seventy-five percent (75%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation provided he/she was not an **Owner/Operator**. If he/she was an **Owner/Operator**, then we will use 33% of the gross income.]

Insured Person must produce proof of his or her gross income and the number of weeks worked. Otherwise, the **Company** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the **Maximum Weekly Benefit Amount**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the first day of **Temporary Total Disability** after the **Waiting Period** and on the same day of each week thereafter.

Continuous Care means monthly monitoring or evaluation of the disabling condition by a **Physician**. The **Company** must receive proof of continuing **Temporary Total Disability** on a monthly basis.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following, which are considered separate periods of disability:
1. successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which the **Insured Person** is not **Temporarily Totally Disabled**; or
2. successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least six (6) months during which the **Insured Person** is not **Temporarily Totally Disabled**.

Temporary Total Disability or Temporarily Totally Disabled means disability that:
1. prevents an **Insured Person** from performing the **Material and Substantial Duties** of his or her occupation [as a commercial truck driver];
2. requires the care and treatment of a **Physician**; and
3. requires that and results in the **Insured Person** receiving **Continuous Care**.

If the **Insured Person** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured Person** shall not qualify for the Temporary Total Disability Benefit. During this period, the **Insured Person** cannot engage in any activity which results in earned income.

Material and Substantial Duties means a duty or duties which the **Insured Person** is required to perform under the terms of the written contract with the **Policyholder** or **Owner/Operator** and as described in the **Insured Person's** application.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Temporary Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which the **Insured Person's** dependents may qualify because of the **Insured Person's** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; and
4. the amount the **Insured Person** receives as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

The **Insured Person** must provide tax schedules and returns to the **Company** for the purpose of calculating this offset.

CONTINUOUS TOTAL DISABILITY BENEFIT
If **Injury** to the **Insured Person** resulting in **Temporary Total Disability** subsequently results in **Continuous Total Disability**, the **Company** will pay the following, after the **Waiting Period**:

1. for each month of a **Continuous Total Disability**, the Continuous Total Disability Benefit is four and three-tenths (4.3) times the **Weekly Benefit Amount** for **Temporary Total Disability**; or
2. for less than a full **Benefit Week** of **Continuous Total Disability**, the Continuous Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Continuous Total Disability**, but only if:
   a. Temporary Total Disability Benefits ceased solely because the **Maximum Benefit Period** has been reached, but the **Insured Person** remains disabled;
   b. the **Insured Person** is not within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration, on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached;
   c. the **Insured Person** has been granted a Social Security disability award for his or her disability (if the **Insured Person** cannot meet the credit requirement for a Social Security disability award he or she cannot qualify for the Continuous Total Disability Benefit even if he or she would otherwise qualify);
   d. the **Insured Person's** disability is reasonably expected to continue without interruption until he or she dies and is substantiated by objective medical evidence satisfactory to the **Company**;
   e. the **Injury** resulting in a **Continuous Total Disability** occurred before the **Insured Person** is within six (6) months or less of attaining their full Social Security retirement age, as defined by the United States Social Security Administration; [and]
   f. the **Injury** began within the **Commencement Period** [.] [; and]
   g. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**.]

The Continuous Total Disability Benefit shall cease on the earliest of the following:
1. the date the **Insured Person** is no longer **Continuously Totally Disabled**;
2. the date the **Insured Person** dies;
3. the date the **Insured Person's** Social Security disability award ceases;
4. the date the **Maximum Benefit Period** has been reached;
5. the date that the **Maximum Benefit Amount** has been paid; or
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to the **Company**.

For this benefit, the following definitions apply:
Average Weekly Earnings will be calculated as follows:
1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income the **Insured Person** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [thirty-three percent (33%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income the **Insured Person** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If the **Insured Person** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. The **Insured Person** will have to produce proof of the number of weeks worked, if he or she worked less than twelve (12) weeks. If the **Insured Person** sustains an **Injury** within seven (7) days of his or her contract date with the **Policyholder**, we will use [seventy-five percent (75%)] of the average gross income received by the other **Insured Persons**, who were contracted within the last three (3) months prior to the covered **Injury**. If the **Insured Person** and/or the **Policyholder** is unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then we will use [seventy-five percent (75%)] of the gross income the **Insured Person** received in the prior year as shown on his or her federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of his or her prior occupation provided he/she was not an **Owner/Operator**. If he/she was an **Owner/Operator**, then we will use 33% of the gross income.]

The **Insured Person** must produce proof of his or her gross income and the number of weeks worked. Otherwise, the **Company** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the Maximum Weekly Benefit. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Total Disability or Continuously Totally Disabled means disability that:
1. prevents an **Insured Person** from performing the duties of any occupation for which he or she is qualified by reason of education, training or experience;
2. requires the care and treatment of a **Physician**; and
3. requires that, and results in, the **Insured Person** receiving **Continuous Care**.

The **Company** must receive proof of continuing **Continuous Total Disability** on a quarterly basis; provided however, that the **Company** may waive requirements 2 and 3. If the **Insured Person** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured Person** shall not qualify for **Continuous Total Disability**. During this period, the **Insured Person** cannot engage in any activity which results in earned income.

Continuous Care means at least quarterly monitoring or evaluation of the disabling condition by a **Physician**.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Continuous Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which the **Insured Person's** dependents may qualify because of the **Insured Person's** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; or
4. the amount the **Insured Person** receives as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

The **Insured Person** must provide tax schedules and returns to the **Company** for the purpose of calculating this offset.

ACCIDENT MEDICAL EXPENSE BENEFIT
If an **Insured Person** suffers an **Injury** requiring treatment by a **Physician** within the **Commencement Period**, the **Company** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Services or Charges** received or incurred due to such **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** for all **Injuries** caused by a single **Accident**, subject to any applicable **Deductible Amount**.

For this benefit, the following definitions apply:
Ambulatory Medical Center means a facility that:
1. operates under the laws of the state in which it is situated;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility.

Ambulatory Medical Center does not include a **Hospital**, **Physician's** office or clinic.

Custodial Services means any services which are not intended primarily to treat a specific injury. **Custodial Services** include, but shall not be limited to, services:
1. related to watching or protecting the **Insured Person**;
2. related to performing or assisting the **Insured Person** in performing any activities of daily living, such as:
   a. walking;
   b. grooming;
   c. bathing;
   d. dressing;
   e. getting in or out of bed;
   f. toileting;
   g. eating;
   h. preparing foods; or
   i. taking medications that can usually be self-administered; and

3. that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment means equipment of a type that is designed primarily for use by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a spa or a stationary bicycle).

Deductible Amount means the total amount of **Medically Necessary Services or Charges** that must be paid by the **Insured Person** before any Accident Medical Expense Benefit is paid under this **Policy**. The **Company** shall not be responsible for any **Medically Necessary Services or Charges** within the **Deductible Amount** as set forth in the **Schedule**.

Extended Care Facility means an institution that meets all of the following requirements:
1. operates under the laws of the state that it is situated in;
2. is approved by the United States Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a registered nurse;
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment of an **Insured Person** in his or her home as part of a treatment plan prescribed by the attending **Physician**, which is provided by a **Hospital** or agency certified to provide such services, but only if it:
1. begins within [seven (7)] days after discharge from a **Hospital**; and
2. follows a **Hospital** confinement of [five (5)] days or more.

Hospital means a facility that:
1. operates under the law of the state in which it is situated;
2. is approved by the United States Department of Health and Human Services or its successor;
3. has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
4. has 24-hour nursing service by registered nurses on duty or on call; and
5. is supervised by one or more **Physicians**.

A **Hospital** does not include:
1. a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care;
2. a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, or any ward, room, wing or other section of a hospital that is used for such purposes; or
3. any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Medically Necessary Services or Charges means one or more of the following, but only if each: (a) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (b) meets generally accepted standards of medical practice; and (c) is ordered by a **Physician** and performed under his or her care, supervision or order:
1. **Hospital** room and board charges or room and board charges in an intensive care unit; **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room); use of an **Ambulatory Medical Center**; and **Hospital** charges for in-patient treatment of a **Mental and Nervous or Depressive Condition**, as shown in the **Schedule**;
2. treatment by a **Physician** of a covered **Mental and Nervous or Depressive Condition** due to an **Injury**, as shown in the **Schedule**;
3. Ambulance service to or from a **Hospital**, as shown in the **Schedule**;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. Physical, Occupational or Work Hardening Therapies, Chiropractic Care and Acupuncture, as shown in the **Schedule**;
9. **Durable Medical Equipment** rental charges, up to the actual purchase price of such equipment;
10. the initial supply, but not any replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes;
11. medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;

12. repair or replacement of **Sound Natural Teeth** damaged or lost as a result of **Injury**, up to the Dental Benefit Maximum, if any, shown in the **Schedule**;
13. **Extended Care Facility**; or
14. **Home Health Care**.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary Services or Charges** for the care and treatment of the **Injury**, including but not limited to: (1) a non-essential private **Hospital** room; (2) television rental; and (3) **Hospital** telephone charges.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary Charge(s) means an amount(s) that:
1. does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and
2. does not include charges that would not have been made if no insurance existed[; and
3. does not exceed the cost of a generic drug, if available. The **Company** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available].

ACCIDENT MEDICAL EXPENSE BENEFIT EXCLUSIONS
In addition to the General Exclusions and Limitations in Section VIII of this **Policy**, **Medically Necessary Services or Charges** do not include expenses for or resulting from any of the following:
1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
2. dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. eye glasses or contact lenses;
4. hearing aids or hearing examinations;
5. rental of **Durable Medical Equipment** if the total rental expense exceeds the usual purchase price for similar equipment in the locality where the expense is incurred, unless authorized by the **Company**;
6. **Custodial Services**;
7. **Personal Comfort or Convenience Items**;
8. services of any government **Hospital** for which an **Insured Person** is not liable for payment;
9. any expenses covered by [Medicare, Medicaid,] a **Third Party** [or any other insurance];
10. expenses incurred which are more than the **Usual and Customary Charge**;
11. cosmetic, plastic or restorative surgery unless otherwise covered;
12. expenses which the **Insured Person** is not legally obligated to pay;
13. an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;
14. any mileage costs or lodging expenses, unless authorized by the **Company**;
15. any translation costs, unless authorized by the **Company**; or
16. **Home Health Care** services provided by an **Immediate Family Member** or **Household Member**.

SECTION VI - ADDITIONAL BENEFITS

[**RETURN OF REMAINS BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay for the transport of the body or remains (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to the **Insured Person's** county of residence. We must be contacted prior to the transportation of the body or remains and we must pre-authorize the transportation for coverage to apply. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**NON-MEDICAL REPATRIATION BENEFIT**

If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accident Medical Expense Benefit and has sufficiently recovered to travel in a regularly scheduled economy class air flight, commercial bus or train and without special medical equipment or personnel with a minimal risk to his or her health, the **Company** will pay for the return to his or her principal residence. We must be contacted prior to the transport and we must agree to the travel itinerary for coverage to apply. This benefit is subject to the prior recommendation of the attending **Physician**. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**AFTER SCHOOL CARE BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit for after school care to the individual who incurs the expense on behalf of each **Dependent Child** who is [ten (10)] years old or less, up to a maximum of the lesser of:
1. [two percent (2%)] of the applicable **Principal Sum** paid under the Accidental Death Benefit per year; or
2. [two thousand dollars ($2,000)] per year.

The after school care provider may not be an **Immediate Family Member** and written proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, to establish continued eligibility for this benefit.

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child** is under age [ten (10)] at the time of each payment. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**COMA BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** and within three hundred sixty-five (365) days of the **Accident** which caused such **Injury**, such **Injury** causes the **Insured Person** to be in a **Coma** for at least thirty-one (31) consecutive days, the **Company** will pay an additional benefit equal to [one percent (1%)] of the **Principal Sum** for such **Injury**, and such amount will be paid each month the **Insured Person** remains in a **Coma** following the initial thirty-one (31) day period. At the end of eleven (11) months of payment, if the **Insured Person** remains in a **Coma**, the **Company** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the eleven (11) months of benefit already received.

The Coma Benefit will end on the earliest of the following:
1. the date the **Insured Person** is no longer in the **Coma**; or
2. the date the **Insured Person** has received a Coma Benefit for eleven (11) months.

The **Company** may require receipt of written proof, at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Coma means a condition determined as such by the **Company's** duly licensed **Physician**.]

[**CRITICAL BURN BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss**, the **Company** will pay an additional benefit equal to the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)], but only if the **Insured Person**:
1. suffered second degree or higher burns over [twenty-five percent (25%)] of his or her body; and
2. has undergone reconstructive surgery to treat the burned areas of the body within three hundred sixty-five (365) days of the occurrence of the **Accident** that caused the **Injury**.]

[**DAY CARE BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit for day care expenses to the individual who incurs the expense for each **Dependent Child** if:
1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and

2. the **Dependent Child** is under age [thirteen (13)].

The Day Care Benefit will be equal to the lesser of:
1. the actual cost of the day care;
2. [three percent (3)%] of the **Principal Sum**; or
3. [three thousand dollars ($3,000)];

and will be paid annually for [four (4)] consecutive years if:
1. the **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. written proof acceptable to the **Company** is received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Accredited Child Care Facility means a properly licensed childcare facility that operates pursuant to state and local laws and has a Tax Identification Number issued by the Internal Revenue Service. **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**FELONIOUS ASSAULT BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** for an **Occupational Injury** payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Paralysis Benefit as a result of a **Felonious Assault** by someone other than himself or herself, an **Insured Person** or an **Immediate Family Member** or **Household Member**, the **Company** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum**, but only if:
1. the **Felonious Assault** occurs while the **Insured Person** is under **Dispatch**; and
2. the crime directly involves the **Policyholder's** or the **Insured Person's** funds or assets.

For this benefit, the following definition applies:

Felonious Assault means the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]

[**HIGHER EDUCATION BENEFIT**
If the **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay a benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**, but only if on the date of the **Accident**, the **Dependent Child**:
1. is enrolled as a full-time student in an accredited college, university or trade school; or
2. is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The Higher Education Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit for all **Dependent Child(ren)** combined is [twenty thousand dollars ($20,000)].]]

[**HIJACKING BENEFIT**
The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions and Limitations of this **Policy** is modified and an **Injury** directly resulting from a **Hijacking** or any attempt at any **Hijacking** is covered under this **Policy**.

This benefit will continue beyond the actual **Hijacking** while the **Insured Person** is:
1. subject to the control of the person(s) making the **Hijacking**; and

2. traveling directly to the **Insured Person's** home or original destination.

For this benefit, the following definition applies:

Hijacking means the unlawful seizure or wrongful exercise of control of a power unit occupied by the **Insured Person**, while the **Insured Person** is getting into, riding in, or getting out of and while under **Dispatch**.]

[**VEHICLE MODIFICATION BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Dismemberment Benefit or Paralysis Benefit, the **Company** will pay an additional benefit equal to the actual cost for modifications to his or her motor vehicle that are necessary to make it accessible or drivable, but only if such **Injury** requires the **Insured Person** to use a wheelchair. Benefits are not payable unless:
1. the modifications are made by a person(s) experienced in such modifications and are recommended by an organization recognized for providing support and assistance to wheelchair users; and
2. proof sufficient to the **Company** is received by the **Company**, establishing eligibility for this benefit.

The maximum amount payable under this benefit will be the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)].]

[**SEAT BELT BENEFIT**
If an **Insured Person** suffers an **Injury** directly resulting from an automobile **Accident** resulting in a **Covered Loss** payable under the Accidental Death Benefit or Survivor's Benefit, the **Company** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum** up to a maximum of [ten thousand dollars ($10,000)], but only if the **Insured Person** was:
1. operating or riding as a passenger in a motorized vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Accident**.

The **Insured Person's** actual use of the seat belt or lap and shoulder restraints must be verified in the official law enforcement report of the **Accident**, through certification by the investigating officers; or by other reasonable proof, acceptable to the **Company**.]

[**SPOUSE RETRAINING BENEFIT**
If an **Insured Person** suffers an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, the **Company** will pay an additional benefit to his or her **Spouse** for the actual cost of any state licensed professional or trade-training program in which the **Spouse** enrolls and completes, but only if the purpose of the program is to obtain an independent source of support and maintenance and the actual cost is incurred within [thirty (30)] months from the death of the **Insured Person**.

The Spouse Retraining Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Spouse** continues his or her training. Before this benefit is paid each year, proof acceptable to the **Company** must be received by the **Company** at such intervals as the **Company** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit is [twenty thousand dollars ($20,000)].]

SECTION VII - LIMITS OF LIABILITY

The **Combined Single Limit of Liability** shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Loss** with respect to an **Insured Person** arising out of **Injury** sustained by such individual as the result of any one **Accident** or Occurrence. The term Occurrence means a single event or related events or originating cause occurring within a 24-hour period.

The **Aggregate Limit of Liability** shown in the **Schedule** is the maximum amount the **Company** will pay under this **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

If either the **Combined Single Limit of Liability** or the **Aggregate Limit of Liability** is not enough to pay all **Covered Loss**, the **Company** will pay reduced benefit amounts based upon the proportion that the **Covered Loss** bears to each benefit or expected total benefits that would otherwise be payable. If the total benefits are unknown, the **Company** will determine the total expected benefits for each **Insured Person**.

Limitation on Multiple **Covered Loss**. If an **Insured Person** suffers more than one **Covered Loss** under one benefit as a result of the same **Accident**, the **Company** will pay only up to the largest **Covered Loss** amount.

Limitation on Multiple Benefits. If an **Insured Person** can recover benefits under two or more of the Accidental Death Benefit, Accidental Dismemberment Benefit, [Coma Benefit] or the Accidental Paralysis Benefit as a result of the same **Accident**, the **Company** will pay only up to the highest applicable **Principal Sum**.

SECTION VIII - GENERAL EXCLUSIONS AND LIMITATIONS

This **Policy** does not cover any losses contributed to or caused by, in whole or in part, by any of the following:

1. [suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** or any **Injury** resulting from a provoked attack;]
2. [sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning [or routine and temporary non chronic sickness or illness such as a cold, cough, headache or nausea];]
3. [a **Pre-existing Condition**, until the **Insured Person** has been continuously covered under this **Policy** for [twelve (12)] consecutive months;]
4. [**Occupational Cumulative Trauma** or **Cumulative Trauma and Repetitive Conditions**, unless shown in the **Schedule**;]
5. [**Occupational Disease**, unless shown in the **Schedule**;]
6. [performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;]
7. [declared or undeclared war, or any act of declared or undeclared war;]
8. [full-time active duty in the armed forces of any country or international authority;]
9. [any **Injury** for which the **Insured Person** is entitled to benefits pursuant to any workers' compensation law or other similar legislation;]
10. [any loss insured by employers' liability insurance;]
11. [the **Insured Person** being intoxicated:
    a. the **Insured Person** is conclusively deemed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether he or she is in fact operating a motor vehicle when the **Injury** occurs; and
    b. an autopsy report from a licensed medical examiner, law enforcement officer reports or similar items will be considered proof of the **Insured Person's** intoxication;]
12. [the **Insured Person** being under the influence of any illegal substance, drug, narcotic, or hallucinogen, unless such drug, narcotic, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage;]
13. [the **Insured Person's** commission of or attempt to commit a felony or a Class A misdemeanor;]
14. [travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the **Insured Person** is:
    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or the **Insured Person**;]
15. [skydiving, parasailing, hang-gliding, bungee-jumping [or any similar activity];] [or]
16. [charges incurred for treatment of a covered **Injury**, when the **Insured Person** obtains compensation for the covered **Injury** from a **Third Party**].

[INCARCERATION LIMITATION

Benefits provided to an **Insured Person** will cease while the **Insured Person** is incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when the **Insured Person** is released from such facility.]

SECTION IX - CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be received by the **Company** within twenty (20) days after an **Insured Person's** loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the **Company** at Zurich American Insurance Company Group Accident Claims Division, [P.O. Box 968041 Schaumburg, IL 60196] with information sufficient to identify the **Insured Person**, is deemed notice to the **Company**.

CLAIM FORMS
The **Company** will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within thirty (30) days after the giving of notice, the claimant will be deemed to have met the Proof of Loss requirements upon submitting, within the time fixed in this **Policy** for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the **Insured Person's** name, the **Policyholder's** name and the Policy Number.

PROOF OF LOSS
Written Proof of Loss acceptable to the **Company** must be received by the **Company** within ninety (90) days after the date of the loss. If the loss is one for which this **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proof acceptable to the **Company** must be received by the **Company**, at such intervals as the **Company** may reasonably require, establishing continued eligibility for the benefit. Failure to furnish such proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time such proof is otherwise required. The **Company** has a right to investigate any documents that the **Insured Person** shall make available to the **Company** upon request.

PAYMENT OF CLAIMS
Upon receipt of written proof of death, payment for loss of life of an **Insured Person** will be made to the **Insured Person's** beneficiary or, if there is no beneficiary designated, the **Insured Person's** survivors in the following order:
1. the **Insured Person's Spouse**;
2. the **Insured Person's** child(ren);
3. the **Insured Person's** parents;
4. the **Insured Person's** brothers and sisters;
5. the **Insured Person's** estate.

Upon receipt of written Proof of Loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the **Insured Person**. If the **Insured Person** dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary or, if there is no beneficiary designated, the **Insured Person's** survivors in the order as listed above.

BENEFICIARY DISIGNATION AND CHANGE
The **Insured Person's** designated beneficiary(ies) is (are) the person(s) so named by the **Insured Person** as shown on the **Policyholder's** records kept on this **Policy**.

A legally competent **Insured Person** over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the **Policyholder** with a written request for change. When the request is received by the **Policyholder**, whether the **Insured Person** is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the **Company** on account of any payment which is made prior to receipt of the request.

Except for the Survivor's Benefit, if there is no designated beneficiary or no designated beneficiary is living after the **Insured Person's** death, payment will be made to the **Insured Person's** estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding one thousand dollars ($1,000) may be made, at the **Company's** option, to any relative by blood or connection by marriage of the payee, who, in the **Company's** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

The **Company** shall pay benefits directly to any **Hospital** or person rendering covered services, unless the **Insured Person** requests otherwise in writing and provides proof that payment was made directly to such **Hospital** or person. Such request must be made no later than the time Proof of Loss is filed. Any payment the **Company** makes in good faith fully discharges the **Company's** liability to the extent of the payment made.

TIME OF PAYMENT OF CLAIM
Benefits payable under this **Policy** for any loss other than loss for which this **Policy** provides any periodic payment will be paid within thirty (30) days upon the **Company's** receipt of written Proof of Loss. Benefits payable periodically under this **Policy** will be paid at four (4) week intervals during the continuance of the period for which the **Company** is liable, subject to the **Company's** receipt of written Proof of Loss, and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

REHABILITATION
The **Company** will consider paying for a rehabilitation program for the **Insured Person** based on an **Occupational Assessment** provided he or she is receiving benefits under either the **Temporary Total Disability Benefit** or the **Continuous Total Disability Benefit**. The rehabilitation program must be mutually agreed upon by the **Insured Person** and the **Company**. The extent of the **Company's** participation will be determined solely by the **Company**. Any benefits payable will continue during the **Insured Person's** rehabilitation unless otherwise agreed to by the **Company**.

SUNSET
In no event shall benefits under this **Policy** be payable unless written Proof of Loss is received by the **Company** within [three (3) years] from the date of the **Accident**.

[**ARBITRATION**
Any contest to a claim denial under this **Policy** shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration shall occur at the offices of the American Arbitration Association nearest to the **Insured Person** or the person claiming to be the beneficiary. The arbitrator(s) shall not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Insured Person** or the person claiming to be the beneficiary is a citizen of a state where the law does not allow binding arbitration in an insurance policy but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. [Non-binding arbitration is required and no legal action may be brought by the **Insured Person**, the beneficiary, or the **Company** until thirty (30) days after the arbitrator(s) issues a non-binding award.] This provision bars the institution of any individual or class action lawsuit brought by the **Insured Person** or the beneficiary.]

SECTION X - GENERAL PROVISIONS

ENTIRE CONTRACT
This **Policy**, together with any riders, endorsements, amendments, applications, enrollment forms and attached papers, if any, make up the entire contract between the **Policyholder** and the **Company**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by an **Insured Person** will be used in any contest unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or personal representative.

No changes in this **Policy** will be valid until approved by an officer of the **Company**. The approval must be noted on or attached to this **Policy**. No agent may change this **Policy** or waive any of its provisions.

CERTIFICATE OF INSURANCE
The **Company** will provide the **Policyholder** with a Certificate of Insurance, in either paper or electronic format, for delivery to each **Insured Person**, where required by state law. Such Certificate of Insurance will contain a summary of terms that affect benefits.

INCONTESTABILITY
The validity of this **Policy** will not be contested after it has been in force for two year(s) from the Policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

POLICYHOLDER RECORDS
The **Policyholder** will keep a record of the coverage, premium, beneficiary designation and other pertinent administrative information for each **Insured Person** which, if acceptable to the **Company**, shall be deemed to be a part of this **Policy**. The **Company** may examine these records at any reasonable time while the **Policy** is in force and for six (6) years after the termination of this **Policy**. The **Policyholder** will report to the **Company** within a reasonable time all changes in information regarding an **Insured Person**. [The **Policyholder** shall indemnify the **Company** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the administration described herein.]

PHYSICAL EXAMINATION AND AUTOPSY
The **Company** has the right, at its own expense, to examine the **Insured Person** whose **Injury** is the basis of a claim, when and as often as it may be reasonably required while a claim is pending. The **Company** may also require an autopsy where it is not prohibited by law.

LEGAL ACTIONS
In those states where binding arbitration is not allowed, no legal action for a claim can be brought against the **Company** until sixty (60) days after receipt of written Proof of Loss. In those states where binding arbitration is not allowed, no legal action for a claim can be brought against the **Company** more than three (3) years (six (6) years in South Carolina and Wisconsin, five (5) years in Kansas, Florida and Tennessee) after the time for giving written Proof of Loss. In those states where binding arbitration is allowed, binding arbitration shall supersede this provision.

NONCOMPLIANCE WITH POLICY REQUIREMENTS
Any express waiver by the **Company** of any requirements of this **Policy** will not constitute a continuing waiver of such requirements. Any failure by the **Company** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

CONFORMITY WITH STATE STATUTES
Any provision of this **Policy** that, on its effective date, is in conflict with the statutes of the state in which the **Policy** was delivered, is hereby amended to conform to the minimum requirements of such laws.

CLERICAL ERROR
Clerical error, whether by the **Policyholder**, the Producer or the **Company**, in keeping records pertaining to this **Policy**, will not:
1. invalidate coverage otherwise validly in force; or
2. continue coverage otherwise validly terminated.

DATA REQUIRED
The **Policyholder** must maintain adequate records acceptable to the **Company** and provide any information required by the **Company** relating to this insurance.

AUDIT
The **Company** will have the right to inspect and audit, at any reasonable time, all records and procedures of the **Policyholder** that may have a bearing on this insurance.

ASSIGNMENT
This **Policy** is non-assignable.

SUBROGATION
The **Company** has the right to recover all payments including future payments, which the **Company** has made to the **Insured Person** or on behalf of the **Insured Person's** covered dependents, heirs, guardians or executors or will be obligated to pay in the future to the **Insured Person**, from any **Third Party**. If the **Insured Person** recovers from any **Third Party**, the **Company** will be reimbursed first from such recovery to the extent of the **Company's** payments to the **Insured Person**. The **Insured Person** agrees to assist the **Company** in preserving its rights against any **Third Party**, including but not limited to, signing subrogation forms supplied by the **Company**.

[**MADE WHOLE DOCTRINE**
The **Company** has the right to recover any and all first monies paid (or payable) to or on behalf of the **Insured Person** and to any and all claims of or on behalf of the **Insured Person**, to the extent of benefits paid by this **Policy**, and regardless of whether or not the beneficiary has been made whole. Made whole shall include first dollar recovery with no offset for attorneys' fees.]

RIGHT TO RECOVER OVERPAYMENTS
In addition to any rights of recovery, reimbursement or subrogation provided to the **Company** herein, when payments have been made by the **Company** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this **Policy**, the **Company** shall have the right to recover such excess payment, from any person to whom such payments were made. The **Company** maintains the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under the **Policy** to the extent of the overpayment.

CONDITIONAL CLAIM PAYMENT
If an **Insured Person** suffers a **Covered Loss** as the result of an **Injury** for which a **Third Party** may be liable, the **Company** will pay the amount of benefits otherwise payable under this **Policy**. However, if the **Insured Person** receives payment from the **Third Party**, the **Insured Person** agrees to refund to the **Company** the lesser of:
1. the amount actually paid by the **Company** for such **Covered Loss**; or
2. an amount equal to the sum actually received from the **Third Party** for such **Covered Loss**.

If the **Insured Person** does not receive payment from the **Third Party** for such **Covered Loss**, the **Company** reserves the right to subrogate under the Subrogation clause of this **Policy**.

At the time such **Third Party** liability is determined and satisfied, this amount shall be paid whether determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.

[**OFFSET DEBT**
The **Company** will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from the **Policyholder** to the **Company** against any balance or balances, whether on account of losses or otherwise, due from the **Company** to the **Policyholder**.]

[**CLAIMS FOR WORKERS' COMPENSATION AND OTHER INSURANCE**
No benefits shall be payable under this **Policy** for any loss for which the **Insured Person** claims or files for any workers' compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, the **Company** shall determine its liability under this **Policy**. The **Company** reserves the right to recover, from the **Insured Person**, any benefits paid under this **Policy** that are subsequently paid for under any workers' compensation, employers' liability, occupational disease or similar law or any other insurance.]

[Workers' Compensation Indemnification. If an **Insured Person** is determined by a court of law or the appropriate state regulatory authority to be covered under workers' compensation insurance for a **Covered Loss**, any benefits for which the **Insured Person** is eligible under this **Policy**, are payable to the person who was determined to be the **Insured Person's** employer or such person's designee or assignee.]

SECTION XI – IMPORTANT NOTICE

The Insured Person may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if they need assistance in resolving any complaints. Or, the Insured Person may write to Zurich American Insurance Company at their administrative offices at [XXXXXX].

Should the Insured Person wish to contact the Arkansas Insurance Department for assistance, they may do so by calling [1-800-282-9134]. Or, the Insured Person may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

[Truckers] [Occupational] Accident Insurance Certificate

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

This is a summary of the accident insurance **We** provide on behalf of the **Policyholder** to **You** if **You** are within a class of eligible persons described in the **Schedule** and if the required premiums are paid when due.

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]

THE INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE ONLY. THE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

THIS IS A SUMMARY OF COVERAGE ONLY WHICH SUMMARIZES AND EXPLAINS THE PARTS OF THE POLICY WHICH APPLY TO YOU.

FOR ALL TERMS AND CONDITIONS OF COVERAGE, PLEASE REVIEW THE POLICY ISSUED TO THE POLICYHOLDER AND ON FILE WITH THEM AT THEIR PLACE OF BUSINESS. YOU CAN OBTAIN A COPY OF THE POLICY FROM THE POLICYHOLDER.

THIS CERTIFICATE IS NOT AN INSURANCE POLICY. IN THE EVENT OF A CONFLICT OF PROVISIONS BETWEEN THE POLICY AND THIS CERTIFICATE, THE PROVISIONS OF THE POLICY WILL GOVERN.

IMPORTANT NOTICE
THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.

PLEASE READ THIS CERTIFICATE CAREFULLY

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THIS CERTIFICATE IS NOT WORKERS' COMPENSATION AND DOES NOT REQUIRE PRE-AUTHORIZATION OF A PHYSICIAN FOR COVERED SERVICES OR TREATMENT. YOU MAY CONSULT US AT [1-888-889-5330] TO DETERMINE IF A SERVICE OR TREATMENT IS COVERED. WE CAN PROVIDE YOU WITH THE NAME AND ADDRESS OF A PHYSICIAN WHO IS A PREFERRED PROVIDER.

YOU CANNOT BE COVERED BY ANY OTHER OCCUPATIONAL ACCIDENT POLICY ISSUED BY **US**. IF **YOU** PAY PREMIUM BUT ARE NOT ELIGIBLE FOR COVERAGE OR DO NOT QUALIFY FOR BENEFITS UNDER THE **POLICY**, **WE** WILL REFUND ANY UNEARNED PREMIUM PAID IN ERROR.

SECTION I - SCHEDULE

Policy Effective Date: [01/01/09]
[**Policy Period**: [01/01/09] to [01/01/10]]
[Policy] Premium Due Date: [01/01/09]
Policy Number: [XXXXXX-XX]

Your Premium: [$0.00]

Policyholder: [Name of Trucking Company]
[Address]
[City, State, Zip]

Eligible Persons

You are eligible to become an **Insured Person** under the **Policy** if **You** meet the following criteria:

CLASS I: **Actively at Work Owner/Operator** who has enrolled for coverage under the **Policy**.
CLASS II: **Actively at Work Contract Driver** who has enrolled for coverage under the **Policy**.

Benefits Summary

	Occupational Injuries	**Non-Occupational Injuries**
☐ Accidental Death Benefit:		
Principal Sum*	[$50,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Survivor's Benefit:		
Principal Sum*	[$175,000.00]	[$7,500.00]
Monthly Benefit Percentage of **Principal Sum**	[1.0%]	[1.0%]
Monthly Benefit Amount	[$1,750.00]	[$1,750.00]
☐ Accidental Dismemberment Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accidental Paralysis Benefit:		
Principal Sum*	[$225,000.00]	[$7,500.00]
Commencement Period	[365 days]	[365 days]
☐ Accident Medical Expense Benefit:		
Commencement Period	[90 days]	[90 days]
Deductible Amount	[$0.00]	[$0.00]
Maximum Benefit Amount	[$1,000,000.00]	[$5,000.00]
Maximum Benefit Period	[104 weeks]	[52 weeks]
Dental Benefit Maximum	[$2,500.00]	[$1,000.00]
Lifetime **Maximum Benefit Amount**	[$1,000,000.00]	[$10,000.00]
Physical, Occupational, or Work Hardening Therapies	To a maximum-combined [36] visits	[N/A]
Ambulance for Medically Necessary Services	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**	[1] round trip to and from a **Hospital** to a Maximum of [$10,000.00] per **Accident**

	Occupational Injuries	Non-Occupational Injuries
Acupuncture Care and Chiropractic Care	[$1,000.00] per **Injury**	N/A
[Hernia Coverage]	[$10,000.00]	N/A
[Hemorrhoid Coverage]	[$10,000.00]	N/A
Mental and Nervous or Depressive Condition	1 visit per day to a maximum of [$25.00] per visit and [20] visits per **Accident**	N/A
[**Occupational Cumulative Trauma**]	[$20,000.00]	N/A
[**Occupational Disease**]	[$20,000.00]	N/A

☐ Temporary Total Disability Benefit:

Commencement Period	[90 days]	[90 days]
Waiting Period	[7 days]	[7 days]
Benefit Percentage	[70.0%]	[70.0%]
Minimum Weekly Benefit Amount	[$125.00]	[$125.00]
Maximum Weekly Benefit Amount	[$500.00]	[$500.00]
Maximum Benefit Period**	[104 weeks]	[12 weeks]
[**Maximum Benefit Period** for Hernia]	[90 days]	N/A
[**Maximum Benefit Period** for Hemorrhoid]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Cumulative Trauma**]	[90 days]	N/A
[**Maximum Benefit Period** for **Occupational Disease**]	[90 days]	N/A

☐ Continuous Total Disability Benefit: ***

Waiting Period	[equals **Maximum Benefit Period** for **Temporary Total Disability**]	N/A
Benefit Percentage	[70.0%]	N/A
Minimum Weekly Benefit Amount	[$50.00]	N/A
Maximum Weekly Benefit Amount	[$500.00]	N/A
Maximum Benefit Amount	[$300,000.00]	N/A
Maximum Benefit Period	Up to age 70, but not beyond full Social Security retirement age	N/A

☐ Additional Benefits:

[Return of Remains Benefit]	[Refer to SECTION VI]	N/A
[Non-Medical Repatriation Benefit]	[Refer to SECTION VI]	N/A
[After School Care Benefit]	[Refer to SECTION VI]	N/A
[Coma Benefit]	[Refer to SECTION VI]	N/A
[Critical Burn Benefit]	[Refer to SECTION VI]	N/A
[Day Care Benefit]	[Refer to SECTION VI]	N/A
[Felonious Assault Benefit]	[Refer to SECTION VI]	N/A
[Higher Education Benefit]	[Refer to SECTION VI]	N/A
[Hijacking Benefit]	[Refer to SECTION VI]	N/A
[Vehicle Modification Benefit]	[Refer to SECTION VI]	N/A
[Seat Belt Benefit]	[Refer to SECTION VI]	N/A
[Spouse Retraining Benefit]	[Refer to SECTION VI]	N/A

Limits of Liability:

Combined Single Limit of Liability	[$1,000,000.00]	[$10,000.00]
Aggregate Limit of Liability	[$2,000,000.00]	[$15,000.00]
Sub Limits of Liability:		
[**Combined Single Limit of Liability** for:		
[Hernia]	[$20,000.00]	N/A

	Occupational Injuries	Non-Occupational Injuries
[Hemorrhoid]	[$20,000.00]	N/A
[**Occupational Disease**]	[$50,000.00]	N/A
[**Occupational Cumulative Trauma**]	[$50,000.00]	N/A

* Starting at age [65], the **Principal Sum** shall be based on the following schedule:

Age at Date of Loss	Percent of **Principal Sum**
[65]	[80%]
[66]	[60%]
[67]	[40%]
[68]	[20%]
[69]	[15%]
[70 and over]	[10%]

** If **You** suffer an **Injury** at or after age [70], the **Maximum Benefit Period** shall be [one (1) year].

*** If **You** sustain an **Injury** within six months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration, **You** do not qualify for the Continuous Total Disability Benefit.

SECTION II - GENERAL DEFINITIONS

Accident means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while coverage is in effect under the **Policy**.

Actively at Work means under **Dispatch** for at least [30] hours each week.

Aggregate Limit of Liability shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

Assignment means the **Policyholder** has offered and **You** have accepted a shipment of freight as recorded in the books and records of the **Policyholder** in the ordinary course of business.

Certificate means this [Truckers] [Occupational] Accident Insurance Certificate.

Company means Zurich American Insurance Company.

Co-Owner means a person who has partial ownership of a vehicle operating as an **Owner/Operator**.

Combined Single Limit of Liability means, with respect to **You**, the maximum amount that **We** will pay for all **Covered Loss** under the **Policy** for or in connection with **Injury** to **You** resulting from any one **Accident**. When the **Combined Single Limit of Liability** has been reached, no further benefits shall be payable under the **Policy**, with respect to **You**, for or in connection with **Injury** sustained as the result of that one **Accident**.

Commencement Period means the period between the date of the **Accident** that caused the **Injury** and the date on which the **Covered Loss** must occur for benefits to be payable under the Accidental Death Benefit, the Accidental Dismemberment Benefit, Accidental Paralysis Benefit, Accident Medical Expense Benefit and/or the Temporary Total Disability Benefit.

Contract Driver means an individual who:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [is authorized by an **Owner/Operator** to operate a power unit owned or leased by an **Owner/Operator** and must neither own nor lease the power unit;]
3. [is compensated on a basis other than time expended in the performance of work;]
4. [is responsible for determining the route and time for **Assignment**;]
5. [has the principal duty to operate the power unit;]

6. [is classified as an independent contractor by the **Policyholder** and the **Owner/Operator** who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance, or for any other purpose, [unless workers' compensation coverage is not mandatory for such person as an employee of either the **Policyholder** or **Owner/Operator**];] and
7. [receives for federal income tax reporting purposes a 1099 and not a W-2].

Covered Loss, in the singular or plural, means one or more of the losses or expenses identified in Sections V and VI of this **Certificate** that are not specifically excluded herein.

Cumulative Trauma or Repetitive Conditions means **Non-Occupational** conditions that impair the normal physiological function of the body over an extended period, but do not arise as the result of a single **Accident**.

Dependent Child(ren) means **Your** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption, who are:
1. under age 19 or under age 23 if he or she [:] [(a)] is enrolled in accredited institution of higher learning on a full-time basis, [and (b) relies on **You** for more than 50% of his or her support and is taken as a dependent on **Your** Federal Income Tax Return]; or
2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on **You** for support and maintenance as defined herein.

We may require proof of the **Dependent Child(ren)'s** incapacity and dependency within 60 days before the **Dependent Child(ren)** reached the age limit specified above. **We** may request that satisfactory proof of the **Dependent Child(ren)'s** continued incapacity and dependency be submitted to **Us** on an annual basis.

Dispatch means the time during which **You** are on **Assignment** or **You** are performing tasks prior to or after an **Assignment** to prepare the contracted vehicle for a current or future **Assignment**. **Dispatch** must be authorized by the **Policyholder** and includes the following:
1. in route to pick up a load;
2. picking up a load;
3. in route to delivering a load;
4. unloading a load;
5. the waiting time for a load;
6. returning from delivering a load;
7. in route to, returning from or performing a pre-trip inspection as required by a recognized governmental agency and/or the contracted motor carrier;
8. [while performing vehicle maintenance or repairs on the contracted vehicle during any of the foregoing times; and]
9. [while performing verifiable vehicle maintenance or repairs on the contracted vehicle; and]
10. performing activities to comply with federal or state laws or to satisfy contracted motor carrier requirements.

Eligible Person(s) means a Class I or Class II individual described in the **Schedule**.

Household Member means a person who maintains residence at the same address as **You** and is not an **Immediate Family Member**.

Immediate Family Member means **Your Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, stepparent, brother, sister, stepbrother, stepsister, child, child who has been legally adopted, or stepchild.

Injury, in the singular or plural, means bodily injury caused by an **Accident**, which occurs while **You** are covered under the **Policy** and the **Injury** must result directly and independently of all other causes, in a **Covered Loss**. All **Injuries** sustained by **You** in any one **Accident** shall be considered a single **Injury**.

Insured Person(s) means an **Owner/Operator** or **Contract Driver**:
1. who is enrolled for coverage under the **Policy**;
2. who has paid the required premium when due; and
3. whose coverage is in effect under the **Policy**.

Maximum Benefit Amount means the maximum amount that **We** will pay under the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Amount** is shown in the **Schedule**.

Maximum Benefit Period means the maximum period that **We** will pay benefits, after the **Waiting Period**, under the Temporary Total Disability Benefit, the Continuous Total Disability Benefit or the Accident Medical Expense Benefit. The applicable **Maximum Benefit Period** is shown in the **Schedule**.

Maximum Weekly Benefit Amount means the maximum amount that **We** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Maximum Weekly Benefit Amount** is shown in the **Schedule**.

Mental and Nervous or Depressive Condition means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.

Minimum Weekly Benefit Amount means the minimum amount that **We** will pay each week under the Temporary Total Disability Benefit or the Continuous Total Disability Benefit. The applicable **Minimum Weekly Benefit Amount** is shown in the **Schedule**.

Non-Occupational means benefits payable for an **Injury** due to an **Accident** sustained by **You** while not under **Dispatch**.

Occupational means, with respect to an activity, **Accident**, incident, circumstance or condition involving **You**, that the activity, **Accident**, incident, circumstance or condition occurs or arises out of or in the course of **You** performing services within the course and scope of contractual obligations for the **Policyholder**, and while under **Dispatch**. **Occupational** does not encompass any period during the course of everyday travel to and from work, other than as allowed under **Dispatch**, or while on vacation.

Occupational Assessment means a test of vocational capabilities, including review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), and evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

Occupational Cumulative Trauma means bodily injury that impairs the normal physiological function of the body caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time and does not arise as the result of a single **Accident**, when:
1. such condition is diagnosed by a **Physician**;
2. **Your** last day of last performance of the activities causing the bodily injury occurred while **Your** coverage is in effect; and
3. such bodily injury resulted directly, and independently of all other causes, in a **Covered Loss**.

Occupational Disease means a sickness that results in disability or death, and is caused by exposure to environmental or physical hazards during the course of **Your Occupational** activities, when:
1. such sickness is diagnosed by a **Physician** and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards;
2. exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which **You** perform **Occupational** activities;
3. **Your** last day of last exposure to the environmental or physical hazards causing such sickness occurs while **Your** coverage is in effect; and
4. such exposure results directly and independently of all other causes in a **Covered Loss**.

Owner/Operator means an individual who leases to or from the **Policyholder** and:
1. [has a valid and current commercial driver's license on the effective date of enrollment;]
2. [owns or leases a power unit;]
3. [is responsible for the maintenance and operating costs of the power unit, including, but not limited to fuel, repairs and supplies;]
4. [is compensated on a basis other than time expended in the performance of work;]
5. [is responsible for determining the route and time for **Assignment**;]
6. [has the right to select or reject the load;]
7. [has a written contract or **Assignment** from the **Policyholder** and is classified as an independent contractor by the **Policyholder** and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;] and

8. [receives for federal income tax reporting purposes a 1099 not a W-2].

Physician means a qualified medical doctor acting within the scope of his or her license who is not:
1. **You**;
2. an **Immediate Family Member**;
3. a **Household Member**; or
4. a practitioner retained by the **Policyholder**.

Policy means the [Truckers] [Occupational] Accident Insurance Policy issued to the **Policyholder**.

Policyholder means the entity named as **Policyholder** in the **Schedule**.

Policy Period means the period shown in the **Schedule**, subject to prior termination pursuant to Section III of the **Policy**.

Pre-Existing Condition means a condition for which **You** have sought or received medical advice or treatment at any time during the twelve months immediately preceding **Your** effective date of coverage under the **Policy**.

Principal Sum means the maximum amount that **We** will pay under the Accidental Death Benefit, the Survivor's Benefit, the Accidental Dismemberment Benefit or the Accidental Paralysis Benefit. The applicable **Principal Sum** is shown in the **Schedule** and is subject to the **Combined Single Limit of Liability** and the **Aggregate Limit of Liability**.

Schedule means SECTION I of the **Policy** and this **Certificate**.

Spouse means **Your** legal spouse.

Third Party in the singular or plural means, but is not limited to, the following:
1. the party that caused the **Accident**, **Injury** or other medical condition and any insurer or indemnifier thereof;
2. **Your** insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers; or
3. any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the **Accident**, **Injury** or other medical condition.

Waiting Period means the consecutive number of days **You** must be **Temporarily Totally Disabled** or **Continuously Totally Disabled** before benefits become payable under the **Policy**. Temporary Total Disability Benefits and Continuous Total Disability Benefits are [not] retroactive to the first day of disability. The **Waiting Period** is shown in the **Schedule**.

We, **Us**, and **Our** means Zurich American Insurance Company.

You, **Your**, and **Yourself** means the **Insured Person** to whom a **Certificate** is issued.

SECTION III - EFFECTIVE DATES AND TERMINATION DATES

Policy Effective and Termination Dates

1. Policy Effective Date. The **Policy** begins on the Policy Effective Date shown in the **Schedule** at 12:01 A.M. Standard Time at the address of the **Policyholder** where the **Policy** is delivered.

2. Policy Termination Date. The **Policy** will terminate at 12:01 A.M. Standard Time at the **Policyholder's** address on the earliest of:
   a. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   b. the date specified in the written notice of **Our** intent to terminate the **Policy**, which will be at least [thirty (30)] days after the date **We** send such notice to the **Policyholder's** last known recorded address;
   c. the date specified in the written notice of the **Policyholder's** intent to terminate the **Policy**, which will be at least [thirty (30)]days after the date the **Policyholder** sends such notice to **Us**; or
   d. at the expiration of the **Policy Period**.

   If **We** terminate the **Policy**, any unearned premium will be returned on a pro-rata basis. If the **Policyholder** requests termination, **We** will return any unearned premium paid on a pro-rata basis. Termination will not affect any claim for a **Covered Loss** occurring prior to the effective date of termination.

Owner/Operator's Effective and Termination Dates

1. **Owner/Operator's** Effective Date. An **Owner/Operator's** coverage under the **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Owner/Operator** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Owner/Operator's** Termination Date: An **Owner/Operator's** coverage under the **Policy** ends on the earliest of:
   a. the date the **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   c. the date the **Owner/Operator** requests, in writing, that his or her coverage be terminated; or
   d. the date the **Owner/Operator** ceases to be an **Insured Person**.

Contract Driver's Effective and Termination Dates

1. **Contract Driver's** Effective Date. A **Contract Driver's** coverage under the **Policy** begins on the latest of:
   a. the Policy Effective Date shown in the **Schedule**;
   b. the date the **Contract Driver** becomes an **Insured Person**; or
   c. if an individual application is required, the date the written application is received by the **Policyholder** or an authorized person designated by the **Policyholder**.

   Coverage is not effective until the first premium payment is paid when due. If premium is paid when due, coverage is effective on the later of a, b or c above. If premium is not paid when due, coverage will not be in effect.

2. **Contract Driver's** Termination Date. A **Contract Driver's** coverage under the **Policy** ends on the earliest of:
   a. the date the **Policy** is terminated;
   b. the Policy Premium Due Date shown in the **Schedule**, subject to the Policy Grace Period set forth in Section IV of the **Policy**;
   c. the date the **Contract Driver** requests, in writing, that his or her coverage be terminated;
   d. the date the **Contract Driver** ceases to be an **Insured Person**; or
   e. the date the **Owner/Operator**, with whom the **Contract Driver** is under contract, ceases to be an **Insured Person** and/or whose contract with the **Policyholder** terminated.

A change in **Your** coverage under the **Policy** due to a change in **Your** eligible class or benefit selection becomes effective on the later of: (1) the date the change in **Your** eligible class or benefit selection occurs; or (2) if premium change is required, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

SECTION IV - PREMIUMS

PREMIUMS

Premiums are payable to **Us** in the amount shown in the **Schedule**. **We** may change the required premiums due by giving the **Policyholder** at least [sixty (60) days] advance written notice. **We** may change the required premiums as a condition of any renewal of the **Policy**. **We** may also change the required premiums at any time when any change affecting premiums is made in the **Policy**.

We may re-underwrite and may change the terms and conditions of the **Policy** including the premium rate on the date when the number of **Insured Persons** under the **Policy** exceeds or is less than the number of **Insured Persons** in the prior month by [fifteen percent (15%)] or more. The **Policyholder** shall provide **Us** with written notice of such increase or decrease in the number of **Insured Persons** at least [thirty (30) days] prior to the effective date of such change.

PLAN AND EXPOSURE CHANGES

The **Policyholder** must notify **Us** of any subsidiary or affiliated company that is to be covered under the **Policy**. Such notice must be sent within [thirty (30) days] of the acquisition of such subsidiary or affiliated company. If such notice is not

provided, the newly acquired entity will not be considered a part of the **Policyholder** and the owner/operators or contract drivers will not be **Insured Persons** until the date that notice is provided. **We** have the right to decline coverage or adjust premium based on the changing exposure.

YOUR PREMIUM
Your Premium is shown in the **Schedule** and shall be payable as follows:
1. if **You** enroll on or prior to the fifteenth (15th) day of the month, **You** shall pay an amount equal to the full monthly premium. No premium shall be payable for the last full or partial month of coverage; and
2. if **You** enroll after the fifteenth (15th) day of the month, **You** shall pay a premium equal to the full monthly premium beginning on the first of the month following the month during which coverage becomes effective. With respect to the last full or partial month of coverage, **You** shall pay an amount equal to the monthly premium.

YOUR GRACE PERIOD
A grace period of [thirty-one (31) days] will be provided for the payment of **Your** Premium due after the first premium. **Your** coverage will not be terminated for non-payment of premium during this grace period if **You** pay the premium due by the last day of this grace period. **Your** coverage will terminate if the full amount of the premium due is not paid by the last day of this grace period.

POLICY GRACE PERIOD
A grace period of [thirty-one (31)] days will be provided for the payment of any premium due after the first premium. The **Policy** will not be terminated for nonpayment of premium during this grace period if the **Policyholder** pays all premiums due by the last day of this grace period. The **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of this grace period. No Policy Grace Period will be provided if **We** receive notice to terminate the **Policy** prior to a premium due date.

If **We** expressly agree to accept late payment of a premium without terminating the **Policy**, **We** do so in accordance with the Noncompliance With Policy Requirements provision in Section X of the **Policy**. In such case, the **Policyholder** will be liable to **Us** for any unpaid premiums for the time the **Policy** is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by **Us** in the collection of all overdue amounts.

WAIVER OF PREMIUM
During the period in which **You** are receiving a Temporary Total Disability Benefit or Continuous Total Disability Benefit, premiums will be waived from the first premium due date on or after the benefit begins to the premium due date following the date the benefit ceases, at which time premium payments must resume. If premium payments are not resumed on that date, **Your** coverage under the **Policy** shall terminate on that date. **You** are responsible for reporting Waiver of Premium to the **Policyholder** or an authorized person designated by the **Policyholder** or **Us**.

SECTION V - BENEFITS

ACCIDENTAL DEATH BENEFIT
If **Injury** to **You** results in death within the **Commencement Period**, **We** will pay the **Principal Sum** to the beneficiary in accordance with the Payment of Claims provision in Section IX of the **Certificate**.

SURVIVOR'S BENEFIT
If an Accidental Death Benefit is payable under the **Policy**, **We** will pay the **Monthly Benefit Amount**, up to the **Principal Sum**, to **Your** surviving **Spouse**.

If **You** are not survived by a **Spouse**, or if **Your Spouse** dies or remarries, **We** will pay or continue to pay the Survivor's Benefit to **Your** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. Payment of the **Monthly Benefit Amount** will end on the earliest of the following:
1. the date **Your Spouse** dies or remarries, if there are no **Dependent Child(ren)**;
2. the date **Your** last **Dependent Child** dies or is no longer a **Dependent Child**; or
3. the date the **Principal Sum** has been paid.

If **You** are not survived by a **Spouse** or any **Dependent Child(ren)**, **We** will not pay a Survivor's Benefit.

For this benefit, the following definition applies:

Monthly Benefit Amount means the product of the Monthly Benefit Percentage shown in the **Schedule** multiplied by the **Principal Sum**.

EXPOSURE AND DISAPPEARANCE BENEFIT
If **You** are exposed to weather because of an **Accident**, which results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If **Your** body has not been found within one year after **Your** disappearance, stranding, sinking or wrecking of a power unit in which **You** were an occupant, then it will be presumed, subject to all other terms and provisions of the **Policy**, that **You** have suffered Accidental Death within the meaning of the **Policy**. If **You** are found and identified, **We** have the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT
If **Injury** to **You** results in any one of the **Losses** specified below within the **Commencement Period**, **We** will pay the Percentage of the **Principal Sum** shown below:

For **Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	[100%]
Sight of Both Eyes	[100%]
One Hand and One Foot	[100%]
One Hand and the Sight of One Eye	[100%]
One Foot and the Sight of One Eye	[100%]
One Hand or One Foot	[50%]
Sight of One Eye	[50%]
Thumb and Index Finger of Same Hand	[25%]
Speech and Hearing	[50%]
Speech or Hearing	[25%]

If more than one **Loss** is sustained by **You** as a result of the same **Accident**, only one amount, the largest, will be paid.

For this benefit, the following definition applies:

Loss, in the singular or plural, of a hand or foot means complete severance through or above the wrist or ankle joint; **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye; and **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

PARALYSIS BENEFIT
If **Injury** to **You** results in any Type of Paralysis specified below within the **Commencement Period**, **We** will pay the Percentage of the **Principal Sum** shown below:

Type of Paralysis:	Percentage of the **Principal Sum**
Quadriplegia	[100%]
Paraplegia	[75%]
Hemiplegia	[50%]
Uniplegia	[25%]

If **You** sustain more than one Type of Paralysis as a result of the same **Accident**, only the largest single amount will be considered a **Covered Loss**.

For this benefit, the following definitions apply:

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**.

Paraplegia means the complete and irreversible paralysis of both lower **Limbs**.

Hemiplegia means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body.

Uniplegia means the complete and irreversible paralysis of one **Limb**.

Limb, in the singular or plural, means entire arm or entire leg.

TEMPORARY TOTAL DISABILITY BENEFIT

If **Injury** to **You** results in **Temporary Total Disability** within the **Commencement Period** and **You** are under age [70] on the day the **Temporary Total Disability** begins, **We** will pay the following amount, after the **Waiting Period**:

1. for each week of a **Temporary Total Disability** during a **Single Period of Total Disability** the Temporary Total Disability Benefit is equal to the lesser of:
   a. the Benefit Percentage shown in the **Schedule** of the **Average Weekly Earnings**; or
   b. the **Maximum Weekly Benefit Amount**;
2. for less than a full **Benefit Week** of **Temporary Total Disability**, the Temporary Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. the date **You** are no longer **Temporarily Totally Disabled**;
2. the date **You** die;
3. the date the **Maximum Benefit Period** has been reached; or
4. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**.

For this benefit, the following definitions apply:

Average Weekly Earnings means:

1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income **You** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [thirty-three percent (33%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income **You** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [seventy-five percent (75%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [seventy-five percent (75%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation provided **You** were not an **Owner/Operator**. If **You** were an **Owner/Operator**, then **We** will use 33% of the gross income.]

You must produce proof of **Your** gross income and the number of weeks worked. Otherwise, **We** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the **Maximum Weekly Benefit Amount**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the first day of **Temporary Total Disability** after the **Waiting Period** and on the same day of each week thereafter.

Continuous Care means monthly monitoring or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Temporary Total Disability** on a monthly basis.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following, which are considered separate periods of disability:
1. successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one full day during which **You** are not **Temporarily Totally Disabled**; or
2. successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least six (6) months during which **You** are not **Temporarily Totally Disabled**.

Temporary Total Disability or Temporarily Totally Disabled means disability that:
1. prevents **You** from performing the **Material and Substantial Duties** of **Your** occupation [as a commercial truck driver];
2. requires the care and treatment of a **Physician**; and
3. requires that and results in **Your** receiving **Continuous Care**.

If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** shall not qualify for the Temporary Total Disability Benefit. During this period, **You** cannot engage in any activity which results in earned income.

Material and Substantial Duties means a duty or duties which **You** are required to perform under the terms of the written contract with the **Policyholder** or **Owner/Operator** and as described in **Your** application.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Temporary Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which **Your** dependents may qualify because of **Your** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; and
4. the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

You must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

CONTINUOUS TOTAL DISABILITY BENEFIT
If **Injury** to **You** resulting in **Temporary Total Disability** subsequently results in **Continuous Total Disability**, **We** will pay the following, after the **Waiting Period**:
1. for each month of a **Continuous Total Disability**, the Continuous Total Disability Benefit is four and three-tenths (4.3) times the **Weekly Benefit Amount** for **Temporary Total Disability**; or
2. for less than a full **Benefit Week** of **Continuous Total Disability**, the Continuous Total Disability Benefit is one seventh (1/7) of the **Weekly Benefit Amount** for each day of **Continuous Total Disability**, but only if:
    a. Temporary Total Disability Benefits ceased solely because the **Maximum Benefit Period** has been reached, but **You** remain disabled;
    b. **You** are not within six (6) months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration, on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached;
    c. **You** have been granted a Social Security disability award for **Your** disability (if **You** cannot meet the credit requirement for a Social Security disability award **You** cannot qualify for the Continuous Total Disability Benefit even if **You** would otherwise qualify);
    d. **Your** disability is reasonably expected to continue without interruption until **You** die and is substantiated by objective medical evidence satisfactory to **Us**;
    e. the **Injury** resulting in a **Continuous Total Disability** occurred before **You** are within six (6) months or less of attaining **Your** full Social Security retirement age, as defined by the United States Social Security Administration; [and]

f. the **Injury** began within the **Commencement Period** [.] [; and]
g. [the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**.]

The Continuous Total Disability Benefit shall cease on the earliest of the following:
1. the date **You** are no longer **Continuously Totally Disabled**;
2. the date **You** die;
3. the date **Your** Social Security disability award ceases;
4. the date the **Maximum Benefit Period** has been reached;
5. the date that the **Maximum Benefit Amount** has been paid; or
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**.

For this benefit, the following definitions apply:
Average Weekly Earnings will be calculated as follows:
1. [for **Owner/Operators**:
   [Thirty-three percent (33%)] of the gross income **You** received, less fuel surcharges, in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [thirty-three percent (33%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [thirty-three percent (33%)] of the average gross income received by other **Insured Persons** who were contracted within the last three (3) months prior to the **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [thirty-three percent (33%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation.]
2. [for **Contract Drivers**:
   [Seventy-five percent (75%)] of the gross income **You** received in the twelve (12) weeks prior to the **Injury**, divided by twelve (12). If **You** worked less than twelve (12) weeks prior to the **Injury**, then [seventy-five percent (75%)] of the gross income received, divided by the number of weeks worked. **You** will have to produce proof of the number of weeks worked, if **You** worked less than twelve (12) weeks. If **You** sustain an **Injury** within seven (7) days of **Your** contract date with the **Policyholder**, **We** will use [seventy-five percent (75%)] of the average gross income received by the other **Insured Persons**, who were contracted within the last three (3) months prior to the covered **Injury**. If **You** and/or the **Policyholder** are unwilling or unable to produce any evidence of the gross income received in the twelve (12) weeks prior to the **Injury**, then **We** will use [seventy-five percent (75%)] of the gross income **You** received in the prior year as shown on **Your** federal income tax return with schedules or 1099s, divided by fifty-two (52), regardless of **Your** prior occupation provided **You** were not an **Owner/Operator**. If **You** were an **Owner/Operator**, then **We** will use 33% of the gross income.]

You must produce proof of **Your** gross income and the number of weeks worked. Otherwise, **We** will pay the Minimum Benefit.

Weekly Benefit Amount means the lesser of [seventy percent (70%)] of the **Average Weekly Earnings** or the Maximum Weekly Benefit. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount**.

Benefit Week means a seven (7) day period beginning on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Total Disability or Continuously Totally Disabled means disability that:
1. prevents **You** from performing the duties of any occupation for which **You** are qualified by reason of education, training or experience;
2. requires the care and treatment of a **Physician**; and
3. requires that, and results in, **Your** receiving **Continuous Care**.

We must receive proof of continuing **Continuous Total Disability** on a quarterly basis; provided however, that **We** may waive requirements 2 and 3. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** shall not qualify for **Continuous Total Disability**. During this period, **You** cannot engage in any activity which results in earned income.

Continuous Care means at least quarterly monitoring or evaluation of the disabling condition by a **Physician**.

Offsets
Subject to the **Minimum Weekly Benefit Amount**, the Continuous Total Disability Benefit shall be reduced by:
1. Social Security disability benefits excluding any amounts for which **Your** dependents may qualify because of **Your** disability;
2. Social Security retirement benefits;
3. the amount of any disability income benefits from any **Third Party**; or
4. the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit.

You must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

ACCIDENT MEDICAL EXPENSE BENEFIT
If **You** suffer an **Injury** requiring treatment by a **Physician** within the **Commencement Period**, **We** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Services or Charges** received or incurred due to such **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** for all **Injuries** caused by a single **Accident**, subject to any applicable **Deductible Amount**.

For this benefit, the following definitions apply:
Ambulatory Medical Center means a facility that:
1. operates under the laws of the state in which it is situated;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility.

Ambulatory Medical Center does not include a **Hospital**, **Physician's** office or clinic.

Custodial Services means any services which are not intended primarily to treat a specific injury. **Custodial Services** include, but shall not be limited to, services:
1. related to watching or protecting **You**;
2. related to performing or assisting **You** in performing any activities of daily living, such as:
   a. walking;
   b. grooming;
   c. bathing;
   d. dressing;
   e. getting in or out of bed;
   f. toileting;
   g. eating;
   h. preparing foods; or
   i. taking medications that can usually be self-administered; and
3. that are not required to be performed by trained or skilled medical or paramedical personnel.

Durable Medical Equipment means equipment of a type that is designed primarily for use by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a spa or a stationary bicycle).

Deductible Amount means the total amount of **Medically Necessary Services or Charges** that must be paid by **You** before any Accident Medical Expense Benefit is paid under the **Policy**. **We** shall not be responsible for any **Medically Necessary Services or Charges** within the **Deductible Amount** as set forth in the **Schedule**.

Extended Care Facility means an institution that meets all of the following requirements:
1. operates under the laws of the state that it is situated in;
2. is approved by the United States Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a registered nurse;
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment of **You** in **Your** home as part of a treatment plan prescribed by the attending **Physician**, which is provided by a **Hospital** or agency certified to provide such services, but only if it:

1. begins within [seven (7)] days after discharge from a **Hospital**; and
2. follows a **Hospital** confinement of [five (5)] days or more.

Hospital means a facility that:
1. operates under the law of the state in which it is situated;
2. is approved by the United States Department of Health and Human Services or its successor;
3. has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
4. has 24-hour nursing service by registered nurses on duty or on call; and
5. is supervised by one or more **Physicians**.

A **Hospital** does not include:
1. a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care;
2. a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, or any ward, room, wing or other section of a hospital that is used for such purposes; or
3. any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Medically Necessary Services or Charges means one or more of the following, but only if each: (a) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; (b) meets generally accepted standards of medical practice; and (c) is ordered by a **Physician** and performed under his or her care, supervision or order:
1. **Hospital** room and board charges or room and board charges in an intensive care unit; **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room); use of an **Ambulatory Medical Center**; and **Hospital** charges for in-patient treatment of a **Mental and Nervous or Depressive Condition**, as shown in the **Schedule**;
2. treatment by a **Physician** of a covered **Mental and Nervous or Depressive Condition** due to an **Injury**, as shown in the **Schedule**;
3. Ambulance service to or from a **Hospital**, as shown in the **Schedule**;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. Physical, Occupational or Work Hardening Therapies, Chiropractic Care and Acupuncture, as shown in the **Schedule**;
9. **Durable Medical Equipment** rental charges, up to the actual purchase price of such equipment;
10. the initial supply, but not any replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes;
11. medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
12. repair or replacement of **Sound Natural Teeth** damaged or lost as a result of **Injury**, up to the Dental Benefit Maximum, if any, shown in the **Schedule**;
13. **Extended Care Facility**; or
14. **Home Health Care**.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary Services or Charges** for the care and treatment of the **Injury**, including but not limited to: (1) a non-essential private **Hospital** room; (2) television rental; and (3) **Hospital** telephone charges.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary Charge(s) means an amount(s) that:
1. does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and
2. does not include charges that would not have been made if no insurance existed[; and
3. does not exceed the cost of a generic drug, if available. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available].

ACCIDENT MEDICAL EXPENSE BENEFIT EXCLUSIONS
In addition to the General Exclusions and Limitations in Section VIII of the **Policy**, **Medically Necessary Services or Charges** do not include expenses for or resulting from any of the following:

1. repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
2. dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. eye glasses or contact lenses;
4. hearing aids or hearing examinations;
5. rental of **Durable Medical Equipment** if the total rental expense exceeds the usual purchase price for similar equipment in the locality where the expense is incurred, unless authorized by **Us**;
6. **Custodial Services**;
7. **Personal Comfort or Convenience Items**;
8. services of any government **Hospital** for which **You** are not liable for payment;
9. any expenses covered by [Medicare, Medicaid,] a **Third Party** [or any other insurance];
10. expenses incurred which are more than the **Usual and Customary Charge**;
11. cosmetic, plastic or restorative surgery unless otherwise covered;
12. expenses which **You** are not legally obligated to pay;
13. an **Extended Care Facility** stay that does not follow a **Hospital** confinement of [five (5)] days or more;
14. any mileage costs or lodging expenses, unless authorized by **Us**;
15. any translation costs, unless authorized by **Us**; or
16. **Home Health Care** services provided by an **Immediate Family Member** or **Household Member**.

SECTION VI - ADDITIONAL BENEFITS

[**RETURN OF REMAINS BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay for the transport of **Your** body or remains (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of **Your** body or remains to **Your** county of residence. **We** must be contacted prior to the transportation of **Your** body or remains and **We** must pre-authorize the transportation for coverage to apply. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**NON-MEDICAL REPATRIATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accident Medical Expense Benefit and have sufficiently recovered to travel in a regularly scheduled economy class air flight, commercial bus or train and without special medical equipment or personnel with a minimal risk to **Your** health, **We** will pay for the return to **Your** principal residence. **We** must be contacted prior to the transport and **We** must agree to the travel itinerary for coverage to apply. This benefit is subject to the prior recommendation of the attending **Physician**. The maximum amount payable under this benefit is [one thousand dollars ($1,000)].]

[**AFTER SCHOOL CARE BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit for after school care to the individual who incurs the expense on behalf of each **Dependent Child** who is [ten (10)] years old or less, up to a maximum of the lesser of:
1. [two percent (2%)] of the applicable **Principal Sum** paid under the Accidental Death Benefit per year; or
2. [two thousand dollars ($2,000)] per year.

The after school care provider may not be an **Immediate Family Member** and written proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, to establish continued eligibility for this benefit.

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child** is under age [ten (10)] at the time of each payment. [The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**COMA BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** and within three hundred sixty-five (365) days of the **Accident** which caused such **Injury**, such **Injury** causes **You** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay an

additional benefit equal to [one percent (1%)] of the **Principal Sum** for such **Injury**, and such amount will be paid each month **You** remain in a **Coma** following the initial thirty-one (31) day period. At the end of eleven (11) months of payment, if **You** remain in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the eleven (11) months of benefit already received.

The Coma Benefit will end on the earliest of the following:
1. the date **You** are no longer in the **Coma**; or
2. the date **You** have received a Coma Benefit for eleven (11) months.

We may require receipt of written proof, at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Coma means a condition determined as such by **Our** duly licensed **Physician**.]

[**CRITICAL BURN BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss**, **We** will pay an additional benefit equal to the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)], but only if **You**:
1. suffered second degree or higher burns over [twenty-five percent (25%)] of **Your** body; and
2. have undergone reconstructive surgery to treat the burned areas of **Your** body within three hundred sixty-five (365) days of the occurrence of the **Accident** that caused the **Injury**.]

[**DAY CARE BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense for each **Dependent Child** if:
1. on the date of the **Accident**, the **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and
2. the **Dependent Child** is under age [thirteen (13)].

The Day Care Benefit will be equal to the lesser of:
1. the actual cost of the day care;
2. [three percent (3)%] of the **Principal Sum**; or
3. [three thousand dollars ($3,000)];

and will be paid annually for [four (4)] consecutive years if:
1. the **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. written proof acceptable to **Us** is received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

For this benefit, the following definition applies:

Accredited Child Care Facility means a properly licensed childcare facility that operates pursuant to state and local laws and has a Tax Identification Number issued by the Internal Revenue Service. **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable under this benefit for all children combined is [eight thousand dollars ($8,000)].]

[**FELONIOUS ASSAULT BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** for an **Occupational Injury** payable under the Accidental Death Benefit, Accidental Dismemberment Benefit or Paralysis Benefit as a result of a **Felonious Assault** by someone other than **Yourself**, **You** or an **Immediate Family Member** or **Household Member**, **We** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum**, but only if:
1. the **Felonious Assault** occurs while **You** are under **Dispatch**; and
2. the crime directly involves the **Policyholder's** or **Your** funds or assets.

For this benefit, the following definition applies:

Felonious Assault means the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]

[**HIGHER EDUCATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay a benefit for higher education expenses to the individual who incurs the expense for each **Dependent Child**, but only if on the date of the **Accident**, the **Dependent Child**:

1. is enrolled as a full-time student in an accredited college, university or trade school; or
2. is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The Higher Education Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit for all **Dependent Child(ren)** combined is [twenty thousand dollars ($20,000)].]]

[**HIJACKING BENEFIT**
The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions and Limitations of the **Policy** is modified and an **Injury** directly resulting from a **Hijacking** or any attempt at any **Hijacking** is covered under the **Policy**.

This benefit will continue beyond the actual **Hijacking** while **You** are:

1. subject to the control of the person(s) making the **Hijacking**; and
2. traveling directly to **Your** home or original destination.

For this benefit, the following definition applies:

Hijacking means the unlawful seizure or wrongful exercise of control of a power unit occupied by **You**, while **You** are getting into, riding in, or getting out of and while under **Dispatch**.]

[**VEHICLE MODIFICATION BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Dismemberment Benefit or Paralysis Benefit, **We** will pay an additional benefit equal to the actual cost for modifications to **Your** motor vehicle that are necessary to make it accessible or drivable, but only if such **Injury** requires **You** to use a wheelchair. Benefits are not payable unless:

1. the modifications are made by a person(s) experienced in such modifications and are recommended by an organization recognized for providing support and assistance to wheelchair users; and
2. proof sufficient to **Us** is received by **Us**, establishing eligibility for this benefit.

The maximum amount payable under this benefit will be the lesser of [ten percent (10%)] of the **Principal Sum** or [ten thousand dollars ($10,000)].]

[**SEAT BELT BENEFIT**
If **You** suffer an **Injury** directly resulting from an automobile **Accident** resulting in a **Covered Loss** payable under the Accidental Death Benefit or Survivor's Benefit, **We** will pay an additional benefit equal to [ten percent (10%)] of the **Principal Sum** up to a maximum of [ten thousand dollars ($10,000)], but only if **You** were:

1. operating or riding as a passenger in a motorized vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Accident**.

Your actual use of the seat belt or lap and shoulder restraints must be verified in the official law enforcement report of the **Accident**, through certification by the investigating officers; or by other reasonable proof, acceptable to **Us**.]

[**SPOUSE RETRAINING BENEFIT**
If **You** suffer an **Injury** resulting in a **Covered Loss** payable under the Accidental Death Benefit, **We** will pay an additional benefit to **Your Spouse** for the actual cost of any state licensed professional or trade-training program in which **Your Spouse** enrolls and completes, but only if the purpose of the program is to obtain an independent source of support and maintenance and the actual cost is incurred within [thirty (30)] months from **Your** death.

The Spouse Retraining Benefit will be equal to [five percent (5%)] of the **Principal Sum**, subject to a maximum of [five thousand dollars ($5,000)]. This amount will be paid annually for [four (4)] consecutive years if **Your Spouse** continues his or her training. Before this benefit is paid each year, proof acceptable to **Us** must be received by **Us** at such intervals as **We** may reasonably require, establishing continued eligibility for this benefit.

[The maximum amount payable under this benefit is [twenty thousand dollars ($20,000)].]

SECTION VII - LIMITS OF LIABILITY

The **Combined Single Limit of Liability** shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Loss** with respect to **You** arising out of **Injury** sustained by **You** as the result of any one **Accident** or Occurrence. The term Occurrence means a single event or related events or originating cause occurring within a 24-hour period.

The **Aggregate Limit of Liability** shown in the **Schedule** is the maximum amount **We** will pay under the **Policy** for all **Covered Losses** with respect to all **Insured Persons** arising out of all **Injuries** sustained as the result of any one **Accident**.

If either the **Combined Single Limit of Liability** or the **Aggregate Limit of Liability** is not enough to pay all **Covered Loss**, **We** will pay reduced benefit amounts based upon the proportion that the **Covered Loss** bears to each benefit or expected total benefits that would otherwise be payable. If the total benefits are unknown, **We** will determine the total expected benefits for **You**.

Limitation on Multiple **Covered Loss**. If **You** suffer more than one **Covered Loss** under one benefit as a result of the same **Accident**, **We** will pay only up to the largest **Covered Loss** amount.

Limitation on Multiple Benefits. If **You** can recover benefits under two or more of the Accidental Death Benefit, Accidental Dismemberment Benefit, [Coma Benefit] or the Accidental Paralysis Benefit as a result of the same **Accident**, **We** will pay only up to the highest applicable **Principal Sum**.

SECTION VIII - GENERAL EXCLUSIONS AND LIMITATIONS

The **Policy** does not cover any losses contributed to or caused by, in whole or in part, by any of the following:

1. [suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury** or any **Injury** resulting from a provoked attack;]
2. [sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning [or routine and temporary non chronic sickness or illness such as a cold, cough, headache or nausea];]
3. [a **Pre-existing Condition**, until **You** have been continuously covered under the **Policy** for [twelve (12)] consecutive months;]
4. [**Occupational Cumulative Trauma** or **Cumulative Trauma and Repetitive Conditions**, unless shown in the **Schedule**;]
5. [**Occupational Disease**, unless shown in the **Schedule**;]
6. [performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;]
7. [declared or undeclared war, or any act of declared or undeclared war;]
8. [full-time active duty in the armed forces of any country or international authority;]

9. [any **Injury** for which **You** are entitled to benefits pursuant to any workers' compensation law or other similar legislation;]
10. [any loss insured by employers' liability insurance;]
11. [**You** being intoxicated:
    a. **You** are conclusively deemed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether **You** are in fact operating a motor vehicle when the **Injury** occurs; and
    b. an autopsy report from a licensed medical examiner, law enforcement officer reports or similar items will be considered proof of **Your** intoxication;]
12. [**You** being under the influence of any illegal substance, drug, narcotic, or hallucinogen, unless such drug, narcotic, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage;]
13. [**Your** commission of or attempt to commit a felony or a Class A misdemeanor;]
14. [travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if **You** are:
    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or **You**;]
15. [skydiving, parasailing, hang-gliding, bungee-jumping [or any similar activity];] [or]
16. [charges incurred for treatment of a covered **Injury**, when **You** obtain compensation for the covered **Injury** from a **Third Party**].

[INCARCERATION LIMITATION
Benefits provided to **You** will cease while **You** are incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when **You** are released from such facility.]

SECTION IX - CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be received by **Us** within twenty (20) days after **Your** loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to **Us** at Zurich American Insurance Company Group Accident Claims Division, [P.O. Box 968041 Schaumburg, IL 60196] with information sufficient to identify **You**, is deemed notice to **Us**.

CLAIM FORMS
We will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within thirty (30) days after the giving of notice, the claimant will be deemed to have met the Proof of Loss requirements upon submitting, within the time fixed in the **Policy** for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include **Your** name, the **Policyholder's** name and the Policy Number.

PROOF OF LOSS
Written Proof of Loss acceptable to **Us** must be received by **Us** within ninety (90) days after the date of the loss. If the loss is one for which the **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proof acceptable to **Us** must be received by **Us**, at such intervals as **We** may reasonably require, establishing continued eligibility for the benefit. Failure to furnish such proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time such proof is otherwise required. **We** have a right to investigate any documents that **You** shall make available to **Us** upon request.

PAYMENT OF CLAIMS
Upon receipt of written proof of death, payment for loss of life of **You** will be made to **Your** beneficiary or, if there is no beneficiary designated, **Your** survivors in the following order:
1. **Your Spouse**;
2. **Your** child(ren);
3. **Your** parents;
4. **Your** brothers and sisters;
5. **Your** estate.

Upon receipt of written Proof of Loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) **You**. If **You** die before all payments due have been made, the amount still payable will be paid to **Your** beneficiary or, if there is no beneficiary designated, **Your** survivors in the order as listed above.

BENEFICIARY DISIGNATION AND CHANGE
Your designated beneficiary(ies) is (are) the person(s) so named by **You** as shown on the **Policyholder's** records kept on the **Policy**.

A legally competent **Insured Person** over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the **Policyholder** with a written request for change. When the request is received by the **Policyholder**, whether the **Insured Person** is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to **Us** on account of any payment which is made prior to receipt of the request.

Except for the Survivor's Benefit, if there is no designated beneficiary or no designated beneficiary is living after **Your** death, payment will be made to **Your** estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding one thousand dollars ($1,000) may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

We shall pay benefits directly to any **Hospital** or person rendering covered services, unless **You** request otherwise in writing and provides proof that payment was made directly to such **Hospital** or person. Such request must be made no later than the time Proof of Loss is filed. Any payment **We** make in good faith fully discharges **Our** liability to the extent of the payment made.

TIME OF PAYMENT OF CLAIM
Benefits payable under the **Policy** for any loss other than loss for which the **Policy** provides any periodic payment will be paid within thirty (30) days upon **Our** receipt of written Proof of Loss. Benefits payable periodically under the **Policy** will be paid at four (4) week intervals during the continuance of the period for which **We** are liable, subject to **Our** receipt of written Proof of Loss, and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

REHABILITATION
We will consider paying for a rehabilitation program for **You** based on an **Occupational Assessment** provided **You** are receiving benefits under either the **Temporary Total Disability Benefit** or the **Continuous Total Disability Benefit**. The rehabilitation program must be mutually agreed upon by **You** and **Us**. The extent of **Our** participation will be determined solely by **Us**. Any benefits payable will continue during **Your** rehabilitation unless otherwise agreed to by **Us**.

SUNSET
In no event shall benefits under the **Policy** be payable unless written Proof of Loss is received by **Us** within [three (3) years] from the date of the **Accident**.

[**ARBITRATION**
Any contest to a claim denial under the **Policy** shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration shall occur at the offices of the American Arbitration Association nearest to **You** or the person claiming to be the beneficiary. The arbitrator(s) shall not award consequential or punitive damages in any arbitration under this section. This provision does not apply if **You** or the person claiming to be the beneficiary is a citizen of a state where the law does not allow binding arbitration in an insurance policy but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. [Non-binding arbitration is required and no legal action may be brought by **You**, the beneficiary, or Us until thirty (30) days after the arbitrator(s) issues a non-binding award.] This provision bars the institution of any individual or class action lawsuit brought by **You** or the beneficiary.]

SECTION X - GENERAL PROVISIONS

ENTIRE CONTRACT
The **Policy**, together with any riders, endorsements, amendments, applications, enrollment forms and attached papers, if any, make up the entire contract between the **Policyholder** and **Us**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by **You** will be used in any contest unless a copy of the statement is furnished to **You** or **Your** beneficiary or personal representative.

No changes in the **Policy** will be valid until approved by an officer of **Our's**. The approval must be noted on or attached to the **Policy**. No agent may change the **Policy** or waive any of its provisions.

CERTIFICATE OF INSURANCE
We will provide the **Policyholder** with a Certificate of Insurance, in either paper or electronic format, for delivery to each **Insured Person**, where required by state law. Such Certificate of Insurance will contain a summary of terms that affect benefits.

INCONTESTABILITY
The validity of the **Policy** will not be contested after it has been in force for two year(s) from the Policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

POLICYHOLDER RECORDS
The **Policyholder** will keep a record of the coverage, premium, beneficiary designation and other pertinent administrative information for each **Insured Person** which, if acceptable to **Us**, shall be deemed to be a part of the **Policy**. **We** may examine these records at any reasonable time while the **Policy** is in force and for six (6) years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured Person**. [The **Policyholder** shall indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the administration described herein.]

PHYSICAL EXAMINATION AND AUTOPSY
We have the right, at **Our** own expense, to examine the **Insured Person** whose **Injury** is the basis of a claim, when and as often as it may be reasonably required while a claim is pending. **We** may also require an autopsy where it is not prohibited by law.

LEGAL ACTIONS
In those states where binding arbitration is not allowed, no legal action for a claim can be brought against **Us** until sixty (60) days after receipt of written Proof of Loss. In those states where binding arbitration is not allowed, no legal action for a claim can be brought against **Us** more than three (3) years (six (6) years in South Carolina and Wisconsin, five (5) years in Kansas, Florida and Tennessee) after the time for giving written Proof of Loss. In those states where binding arbitration is allowed, binding arbitration shall supersede this provision.

NONCOMPLIANCE WITH POLICY REQUIREMENTS
Any express waiver by **Us** of any requirements of the **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

CONFORMITY WITH STATE STATUTES
Any provision of the **Policy** that, on its effective date, is in conflict with the statutes of the state in which the **Policy** was delivered, is hereby amended to conform to the minimum requirements of such laws.

CLERICAL ERROR
Clerical error, whether by the **Policyholder**, the Producer or **Us**, in keeping records pertaining to the **Policy**, will not:
1. invalidate coverage otherwise validly in force; or
2. continue coverage otherwise validly terminated.

DATA REQUIRED
The **Policyholder** must maintain adequate records acceptable to **Us** and provide any information required by Us relating to this insurance.

AUDIT
We will have the right to inspect and audit, at any reasonable time, all records and procedures of the **Policyholder** that may have a bearing on this insurance.

ASSIGNMENT
The **Policy** is non-assignable.

SUBROGATION
We have the right to recover all payments including future payments, which **We** have made to **You** or on behalf of **Your** covered dependents, heirs, guardians or executors or will be obligated to pay in the future to **You**, from any **Third Party**. If **You** recover from any **Third Party**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to **You**. **You** agree to assist **Us** in preserving **Our** rights against any **Third Party**, including but not limited to, signing subrogation forms supplied by **Us**.

[**MADE WHOLE DOCTRINE**
We have the right to recover any and all first monies paid (or payable) to or on behalf of **You** and to any and all claims of or on behalf of **You**, to the extent of benefits paid by the **Policy**, and regardless of whether or not the beneficiary has been made whole. Made whole shall include first dollar recovery with no offset for attorneys' fees.]

RIGHT TO RECOVER OVERPAYMENTS
In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** shall have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to **You** (and **Your** assignee) under the **Policy** to the extent of the overpayment.

CONDITIONAL CLAIM PAYMENT
If **You** suffer a **Covered Loss** as the result of an **Injury** for which a **Third Party** may be liable, **We** will pay the amount of benefits otherwise payable under the **Policy**. However, if **You** receive payment from the **Third Party**, **You** agree to refund to **Us** the lesser of:
1. the amount actually paid by **Us** for such **Covered Loss**; or
2. an amount equal to the sum actually received from the **Third Party** for such **Covered Loss**.

If **You** do not receive payment from the **Third Party** for such **Covered Loss**, **We** reserve the right to subrogate under the Subrogation clause of the **Policy**.

At the time such **Third Party** liability is determined and satisfied, this amount shall be paid whether determined by settlement, judgment, arbitration or otherwise. This provision shall not apply where prohibited by law.

[**CLAIMS FOR WORKERS' COMPENSATION AND OTHER INSURANCE**
No benefits shall be payable under the **Policy** for any loss for which **You** claim or file for any workers' compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, **We** shall determine **Our** liability under the **Policy**. **We** reserve the right to recover, from **You**, any benefits paid under the **Policy** that are subsequently paid for under any workers' compensation, employers' liability, occupational disease or similar law or any other insurance.]

[Workers' Compensation Indemnification. If **You** are determined by a court of law or the appropriate state regulatory authority to be covered under workers' compensation insurance for a **Covered Loss**, any benefits for which **You** are eligible under the **Policy**, are payable to the person who was determined to be **Your** employer or such person's designee or assignee.]

SECTION XI – IMPORTANT NOTICE

You may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if You need assistance in resolving any complaints. Or, You may write to Zurich American Insurance Company at their administrative offices at [XXXXXX].

Should You wish to contact the Arkansas Insurance Department for assistance, You may do so by calling [1-800-282-9134]. Or, You may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].